

## **HEALTH SECURITY ACT OF 1993**

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## **HEARINGS**

BEFORE THE

# COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

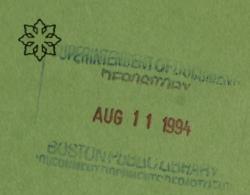
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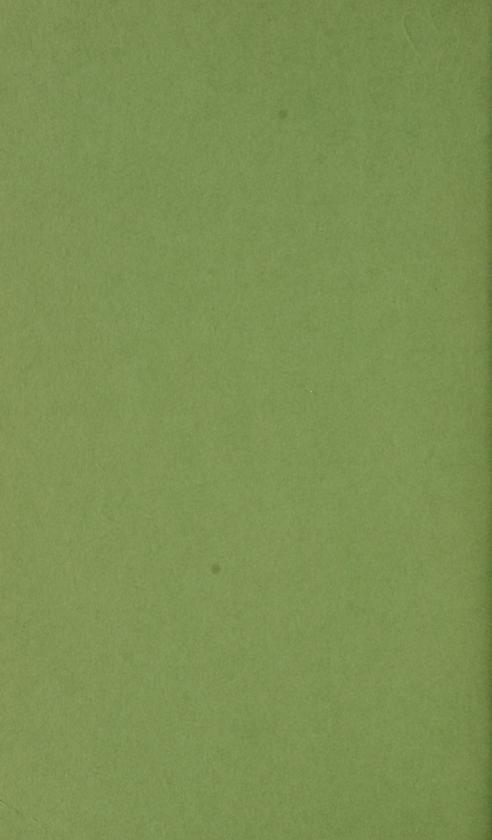
EXAMINING THE ADMINISTRATION'S PROPOSED HEALTH SECURITY ACT, TO ESTABLISH COMPREHENSIVE HEALTH CARE FOR EVERY AMERICAN

JANUARY 26, FEBRUARY 2, 4, 22, MARCH 2 AND 8, 1993

PART 4

Printed for the use of the Committee on Labor and Human Resources





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### HEALTH SECURITY ACT: TRAINING HEALTH PERSONNEL

#### WEDNESDAY, JANUARY 26, 1994

U.S. SENATE, COMMITTEE ON LABOR AND HUMAN RESOURCES, Washington, DC.

The committee met, pursuant to notice, at 10:43 a.m., in room SD-430, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Pell, Metzenbaum, Simon, Wellstone,

Wofford, Kassebaum, Jeffords, Gregg, and Durenberger.

#### **OPENING STATEMENT OF SENATOR KENNEDY**

The CHAIRMAN. The committee will come to order, and I apologize first of all to our witnesses and also to our colleagues. The vote at 10:30 was not expected and put us in a dilemma about commencing the hearing.

I think we are probably as far along as we would be otherwise, since I think everyone will restrict their opening comments. I will

put my full statement in the record.

[The prepared statement of Senator Kennedy follows:]

#### PREPARED STATEMENT OF SENATOR KENNEDY

Today as the new session of Congress begins, we resume our Committee hearings on President Clinton's proposal for health reform. Our topic this morning is the size and composition of the workforce in the health care systems and their role in the spiraling cost of health care.

There are many aspects of this issue. It involves the quality of physicians, nurses, and other health care wofflers, health services, uneven geographic distribution of the inadequate numbers of racial and ethnic minorities among health providers, the excessive number of specialists and the lack of family doctors.

In 1961, half of all U.S. physicians were generalists. By 1990, the ratio had dropped to one-third as the number of specialties has soared. All projections indicate that the ratio will continue to decline as smaller and smaller numbers of medical school graduates plan careers as family doctors.

The increasing imbalance undermines our ability to provide access to universal health care. It also limits our ability to meet the demands of managed care and the needs of under-served rural and

urban communities.

The uneven geographic distribution of physicians remains an intractable problem despite a doubling in the physician supply during the past 25 years. The number of areas with inadequate numbers of family doctors rose between 1980 and 1992, despite a nation-wide increase of 150,000 physicians. An estimated 35 million Americans reside in these under-served areas.

An expanded role for nurses in health reform is a key part of President Clinton's plan. Nurses can fill many of the current gaps In access and availability of primary and preventive health services. Nurse practitioners continue to play a central role in improving access to health care and providing quality and cost-effective care for millions of Americans living in rural and medically under-

served areas.

Academic health centers are the jewel in the crown of the nation's health care system. They train the physicians of the future. They conduct much of the medical research that holds the best hope for preventing, treating, and curing the diseases that shorten the lives and blight the hopes of millions of our fellow citizens. They are the source of the most advanced and complex care for the sickest patients.

The increasingly competitive health market-place we have today is already challenging the viability of these essential institutions. Because of their special role in training, research, and advanced care, academic health centers are inherently higher cost facilities

than other hospitals.

In a competitive market place, no individual health plan will be willing to pay these additional costs—even though the health care system as a whole depends on these high-quality academic health centers. These competitive forces will exist with or without health reform in fact, health reform is our best chance to assure that academic health centers continue to make their indispensable contributions to the nation and the world.

In Massachusetts, and many others states, these health centers are also key components of the local economy, because they are centers of excellence for medical research, training, and advanced

care.

The Committee has been working closely with the Administration to assure that the importance and special needs of academic health centers are recognized. The President's plan contains a number of important provisions to deal with the problems that managed competition may pose, and I look forward to the discus-

sion of these issues today.

The more competitive health marketplace of today also poses special challenges to a broad range of other health care workers, and these challenges will be intensified by health reform. As we will hear today, we can expect—and we need—down-sizing of our hospital system and a shift in emphasis from specialty, inpatient care to outpatient primary care and preventive services. At the same time, health care spending will continue to increase under health reform, and new jobs will be created in biomedical research, outpatient and primary care, and home care.

But to assure that current health care workers are not the innocent victims of reform, we need a clear national policy for retraining dislocated wofflers and providing other forms of assistance. The President's plan includes important provisions in this area, and we intend to work closely with the Administration, with unions representing health workers, and with many others so that those who have worked long and hard to provide quality health care for oth-

ers will find the quality of their own lives protected.

The Health Security Act provides funds for academic health centers for medical education and funds to emphasize primary care training. It also limits the number of specialty residencies and authorizes increased funds for training nurse practitioners and physician assistants. In addition, it establishes a National Council of Graduate Medical Education within the Department of Health and Human Services, and it expands the National Health Service Corps.

Our hearing this morning will deal with many of these important issues. We are fortunate to have as our lead-off witness Dr. Philip Lee, Assistant Secretary for Health, in the Department of Health and Human Services who will discuss the Administration's plan

and its approach to these concerns.

Next, a panel of these distinguished witnesses will discuss the changing and important role of academic health centers in training future health care providers. Dr. John Naught, Dean of the School of Medicine at the State University of New York at Buffalo; Dr. Richard Nesson, President of Brigham & Women's Hospital in Boston; and Dr. Stuart Bondurant, Dean of the School of Medicine at the University of North Carolina at Chapel Hill will make up this panel.

The third panel will address workforce issues from the perspective of primary care physicians, nurses, and physician assistants. I welcome all of our witnesses, and I look forward to their testi-

mony.

The CHAIRMAN. Senator Kassebaum will be here shortly. I know she has some conflicts, so I will ask her if she wishes to inquire

of Dr. Lee at any time that she is here.

Today, we resume our series of hearing on health reform in the Labor and Human Resources Committee. President Clinton introduced the Health Security Act last September, and Mrs. Clinton was the lead-off witness at our first hearing. Since then, the committee has held 40 hearings on health reform in Washington and around the country, and we have scheduled another five hearings between now and the February recess. At that point, we will have covered the principal issues in the legislation, and I commend the members of the committee, Democrats and Republicans alike, for the bipartisan spirit with which they have approached these issues and for their active participation in these hearings.

In addition to the many hearings since September, the committee has held scores of additional hearings on health care in recent years. This issue has been studied by the committee as intensively

as any issue before the Congress.

Now we are approaching the time for action in the committee and on the Senate floor. We will continue to work together to seek as broad a bipartisan solution as possible. As with other measures in the committee in past years and in previous years, such as family and medical leave, national service, and student loan reform, bipartisan cooperation is essential to achieve our goal of health reform.

In the months ahead, as health legislation comes before the full Senate, the Nation deserves an up or down vote on all the key issues that are at the heart of comprehensive health reform. I do not believe opponents will seek to block a vote on health reform by resorting to a filibuster. The American people will not tolerate it. The people of this country will not accept a filibuster on health care. On an issue of this magnitude, they deserve a vote. Senators have a right to disagree with the President or offer alternative proposals, but gridlock is not an acceptable alternative. The people will demand a vote, and we must give it to them.

Senator Kassebaum?

#### OPENING STATEMENT OF SENATOR KASSEBAUM

Senator KASSEBAUM. Mr. Chairman, just a brief word, because the committee is starting late, I only heard the end of your comments.

I am very confident there will not be a filibuster, that as a matter of fact, there is a genuine desire to work together to put a constructive health care package forward. I think the health care reform hearings that we have had here have been important, and I look forward to the continuation of these hearings. I think these hearings produce an important dialogue in understanding what is at stake. Today, Dr. Lee will speak to an area that I think is particularly important as we talk about health care delivery, the importance of primary care physicians, and how we can address the work force issue in the changing health care environment.

Thank you.

The CHAIRMAN. Before we begin I have statements from Senators

Dodd, Thurmond, and Hatch.

[The prepared statements of Senators Dodd, Thurmond, and Hatch follow:]

#### PREPARED STATEMENT OF SENATOR DODD

Mr. Chairman, thank you for holding today's hearing on the training of health care personnel under the Health Security Act. Our health workforce obviously will play a central role in our effort to reform the health care system—they are the backbone of our health care system. The training of this workforce will be important to successful reform if we truly hope to expand access, control cost, ensure high quality care, and emphasize preventive care.

We undoubtedly will increase demand for primary care services as we work to ensure that all Americans have health care coverage. The committee has heard about this need in testimony at hearings last fall. We have heard that there already exists a national shortage of primary care physicians as well as a geographic maldistribution. And if we do not address the problem as we reform our health care system, we will undoubtedly make the problem worse.

care system, we will undoubtedly make the problem worse.

I commend the President for including in the health security act a number of provisions that focus on the training and workforce needs in a reformed health care system. I am interested in hearing the testimony of health care providers on these provisions and

thank the witnesses for appearing before the committee to share their views.

I am particularly interested in the views of academic health centers that play a significant role, not only in workforce training, but also in the conduct of clinical research, medical technology development, and the provision of specialized services to patients with unusual and severe health care problems.

Finally, I want to thank Dr. Philip Lee, the Assistant Secretary of Health at HHS for appearing before the committee this morning.

#### PREPARED STATEMENT OF SENATOR THURMOND

It is a pleasure to be here today to receive testimony concerning the training of health care personnel under S. 1757, the Health Security Act. I would like to join my colleagues in welcoming our witnesses.

As you know, S. 1757, will create the National Council on Graduate Medical Education. This Council and the Secretary of Health and Human Services will be responsible for the development and

support of graduate medical education.

The Council will determine the total number of approved residency positions and the location of each residency. This includes the number of people allowed into training positions for each medical specialty, based on what the Council believes is the national need for new physicians in medical specialties. I believe we must seriously consider whether we should allow total federal control of

these medical positions.

We must also consider the funding of the Graduate Medical Education system. Currently the Medicare program pays approximately \$5 billion annually to teaching hospitals to help them with the costs of residency training. S. 1757 would direct that any institution which continues to train residents for a position not allocated under the Graduate Medical Education system would become ineligible for all Graduate Medical Education funding. This will not allow the flexibility an institution may require to address a specific local need.

Mr. Chairman, I recognize the need for more primary care physicians. Approximately 90 percent of our health care needs can be addressed at the basic levels provided by primary care personnel. These personnel are cost effective and enhance access to medical care. Our rural areas and inner cities would especially benefit from an increased number of primary care providers. However, I believe one of the reasons we have the best health care system in the world is that we have so many individuals who continue their medical education beyond primary care. If we take away the incentives to excel and mandate each position, we will hamper our own advances in medicine.

We should seek to balance our need for more primary care providers without sacrificing the benefits we derive from specializa-

tion.

Again, I would like to welcome our witnesses here today, and I look forward to their testimony.

#### Prepared Statement of Senator Hatch

Thank you Mr. Chairman. And I want to thank the distinguished witnesses present before the Committee this morning for their testimony on what was certainly one of the sleeper issues contained

in President Clinton's health care reform proposal.

Unquestionably, one of the fundamental issues underlying anything that we do to change the health care delivery system in our country is to determine the proper role of the Federal government in insuring that we have the appropriate number and type of health care providers to meet our emerging health care needs.

I must say that I have a certain uneasiness when we begin to tamper with the very institutional structure that has produced the finest health care system with the best health care professionals in the world. As my colleagues know, there has been a considerable amount of alarm over the implications of the President's health reform bill on medical schools and teaching hospitals. Some very serious and, I believe, dangerous, implications for both patients and physicians are being expressed by some of the preeminent teaching institutions in the country. Unfortunately, the people who are really threatened are the American people who have come to expect the highest standards in medical care.

I look forward to the testimony and working with my colleagues

on this fundamental issue.

The CHAIRMAN. If there is no objection, we will move right to Dr. Lee. We have a full agenda today, and we want to accord our third panel courtesy as well in terms of hearing them. So we will ask Dr. Lee for his full testimony, and then I will ask Senator Kassebaum to inquire prior to the time that it will be necessary for her to

One of the areas that I hope you will deal with is the administration's funding stream in terms of the teaching hospitals. I am very concerned about the transition and will we have sufficient time to move the way the administration wants to in terms of the timing. Second, I know you will speak to the issues of the public funding, but there will also be a diminution in terms of private funding for teaching institutions, and I will come back and question you on those areas. Those are basically the areas I will be interested in inquiring of you later.

We will be glad to hear from you, and perhaps you could be good

enough to summarize your statement.

#### STATEMENT OF DR. PHILIP R. LEE, ASSISTANT SECRETARY OF HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERV-ICES, WASHINGTON, DC

Dr. LEE. Thank you very much, Senator Kennedy.

You do have my testimony submitted for the record, and I just want to make a few comments on the work force and academic health center issues.

Senator Kassebaum has indicated the importance of this area in terms of reform. Basically, there are three areas that we believe are critically important. In the principle of security, if you do not have an adequate supply of appropriately trained physicians, nurse practitioners and others in the right place, you will not have the

security that should be guaranteed.

We know that we have a maldistribution geographically, particularly in rural areas and inner cities, and we have a maldistribution by specialty. We have too many medical subspecialists, and we do not have enough generalists—family physicians, general internists, general pediatricians, obstetricians and gynecologists.

Second, in terms of savings, two issues. To achieve the kind of cost savings we are talking about in the future, slowing the rate of increase in expenditures, we have to deal with the issue of aggregate physician supply, and we have to deal with the problem of

specialty distribution.

Studies have demonstrated—and they are limited in number, but they are certainly suggestive—that even with the same outcomes, generalists—the outcomes equivalent—with the same kind of patients provide care at lower cost than particularly procedure-based medical subspecialists. That was a very important study done in Boston. It is not a nationwide study, but it is very suggestive that we can get high-quality care from generalists that is appropriate and can do the job, with the kind of mix that has been proposed.

The third has to do with quality, and this is critical for the academic health centers. They are at the heart of the enterprise that is health care in the United States today. They are widely distributed, principally around medical schools and other health professions schools. We are very concerned with the rapid movement which, irrespective of any legislation, has been taking place in some States like Minnesota, California, Oregon, Washington, New Mexico, and others, where managed care plans are reluctant to pay the academic health centers the additional costs of caring for patients with complex problems and the additional costs of graduate training.

So that to preserve the academic health center, some very explicit policies are necessary, and those institutions are essential, we believe, one, for the research that is necessary, for the clinical research, the basic research, for the graduate training, for the undergraduate training, and for the referral of patients with a wide

range of problems.

To deal with those issues, we have proposed in the President's plan, three funds that would be specifically dealing with these issues. One, to finance the direct costs of graduate medical education—and this builds on the policies that have been established in Medicare by Congress since 1983, where you had a direct fund for graduate medical education. We would create a separate fund with the Medicare moneys and the moneys from private insurance flowing into that separate fund.

The second fund would support graduate nurse education and would be similar, although much smaller. That would be about a

\$200 million fund.

And the third fund would be a fund specifically and explicitly to fund these additional costs in the academic health centers, in the teaching hospitals, and that again is based on the principles that were established in the Medicare indirect payments to those institutions. We feel that separate funds are necessary because, as I said, in the managed care developments, if you do not create a sep-

arate fund, you are not going to be able to protect these institutions

and protect these vital training programs.

Once the funds are established separately, there needs to be a mechanism, particularly with graduate medical education, for decisions about which residency programs are funded. The proposal has said that we should fund the training programs. Now, this is an area where there is a fair amount of discussion going on. Many have suggested that we should fund the institution that incurs the costs, and that makes a lot of sense. That could be a teaching hospital, that could be a group practice, or a health plan that runs a residency program, that could be an ambulatory care center, or it could be an academic health center.

Mayo Foundation, for example, runs 100 different residency programs. It does not make sense to fund 100 different grants to Mayo when they administer and they pay the salaries of those residents.

So those are some of the issues that I think we need to look at

as we examine the proposals that we have put forward.

We have proposed a national council on graduate medical education to make the decisions with respect to which programs get funded. The council would first establish national goals, would then determine on the basis of historical patterns, quality of the residency program, needs in an area, needs by specialty, and in consultation with the teaching institutions involved, with various others who are concerned about these issues, before those decisions get made in an open process.

Our current proposal calls for a distribution of residencies of 55 percent in generalist training programs and 45 percent in specialty programs. And that was in the legislation proposed by 1998. A number of people have said to us we cannot get there in that time, that it is too soon. So that transition, Senator Kennedy, that you mentioned is important, and what that time should be needs to be

really carefully examined.

The second question is how many residencies. Currently, we have 135 percent of the U.S. graduates in residency training programs. We have seen a significant increase in the number of residencies since 1988, and we have proposed in the legislation that the number relate to the U.S. graduates of allopathic and osteopathic medical schools. We did not set a number. Senator Rockefeller has proposed 110 percent, there have been similar figures proposed in the House of Representatives, and a number of groups have suggested that that is a reasonable figure. That is another issue.

If you do 110 percent, and you do that over a period of time, let us say in a 5- or 6-year period, you then reduce the number of residencies in the specialties and oversupply. Over a 5- or 6-year period, you could reach the 55-45 incrementally rather than in the more quick manner than we have proposed in the legislation. So again, that is an issue that we want to work with you on and see

what is the best approach.

For the graduate nurse education, we would propose a council similar to the one in graduate medical education, a process similar to that, and we are working with Professor Linda Aiken at the University of Pennsylvania to help us really develop the procedures, and as we develop that, we will be coming in with much more detail.

On several other related work force issues, additional funding is proposed to expand work force programs in the Public Health Service for the training of generalists, also funding for the Department of Labor, particularly for the retraining of hospital workers, who

may be displaced as there is downsizing.

Finally, the pool that would support the extra costs in the academic health centers. There, as the health plan assures all the hospitals of full funding for the care of patients, you do not need the magnitude of that funding that has been available through the Medicare indirect, because that took care of a number of other issues such as the bad debt and charity care. So that the size of that pool is a question.

We have made some recommendations, and the three pools that we are suggesting actually would total about \$10 billion; this pool would be \$3.7 billion by 1999. That would cover the extra costs related to clinical trials, caring for these patients that are more com-

plex, the extra costs associated with teaching.

We believe that with those three tools, we will provide the essential elements that are necessary to protect the academic health centers. We will require plans to contract with the academic health centers for referral. We will require that they support the routine costs of clinical trials, and we will evaluate the performance of plans with respect to referral of patients to make sure that the plans are in fact referring appropriately, and that needs an adequate data system which is contemplated in the plan.

I think after the President's speech last night, we were all energized to achieve the goals that have been outlined in the Health Security Act. And it is our objective to work very closely with this committee. These are very complex issues on graduate medical education and the academic health centers. We believe they are fundamental to the reform, and we look forward to working with you

to achieve the best policies possible in these areas.

Thank you very much, Mr. Chairman.

[The prepared statement of Dr. Lee may be found in the appendix.]

The CHAIRMAN. Thank you very much.

We will try and follow a 7-minute rule for questions.

Can you tell us a little bit more about the national council? One of the real concerns about the President's program is the question of bureaucracies and whether we are going to be distorting some of the things that work very well in our system, and one of the things that works very well is our teaching hospitals. They are, as you pointed out, enormously important in terms of quality issues, which is going to be one of the major factors. We have the coverage, we have the cost containment, we have clinical preventive services, but quality of care is obviously key to the President and the First Lady, and these teaching centers are essential in terms of this.

How will the council are going to work. Who is going to be on the council? How it is going to be made up? How will they proceed? What do you say to the teaching hospitals that are training some of the world's best, both specialists as well as general practitioners, about how they are going to interrelate with this council, who is going to be on it and how these decisions are going to be made?

Dr. LEE. First of all, the council would be represented by educators, practitioners, consumers, alliances. We have had recommendations from teach hospitals that there be a representative of teaching hospitals. I think the composition we need to review with you all to decide what is the appropriate mix of people on that council to make these critical decisions. Clearly, there would be people who have been involved in the educational process, in the teaching hospitals, in the medical schools, in the graduate training programs.

As we see the process, it would be an open, consultative process. It would be a process that would be gradual. In the beginning, certainly we will look at the historical patterns of funding the training programs. We will look at the quality of those training programs. The quality is really fundamental to this whole enterprise. I mean, if you are going to downsize, you have got to make sure the best

training programs continue to be supported.

There is no intention on our part, at least, to have any mass redistribution geographically. There are some areas that are training more people per capita than other areas. Boston, for example, and New York have been areas that have long attracted physicians from all over the country for residency training.

We do not see, except for this area where there is oversupply of subspecialists particularly, and there, we would be consulting, or the council would be consulting, with the appropriate specialty or-

ganizations, let us say cardiology. How do you downsize?

If you look at the performance of the surgeons since the 1970's, they have had very rigorous review of their residency programs on a quality basis. We do not have an oversupply of general surgeons in this country. And I think it is that kind of process and review that we would hope to follow with the council in making those decisions, and we would certainly not in any way want to diminish the quality. It is the quality programs we want to maintain.

The CHAIRMAN. Well, we want to obviously work with you, be-

cause there is great interest and concern about how that whole

process is going to work.

Now let me ask you in terms of the administration's proposals in support of the teaching hospitals, there are these different funding mechanisms. Maybe you could just review very briefly how you think they compare with the existing streams with the teaching hospitals. And then second, there has to be a recognition that the private sector is going to have some difference in terms of how it is going to proceed. People will go to some of the great teaching and medical centers because they are great teaching and medical centers, with the appropriate and real kinds of effects that those teaching hospitals have in terms of quality, so they will pay somewhat more. Now, that is not going to be there, or I imagine it will be reduced to some extent. So I am interested in what kind of calculations you are making about what is going to happen in terms of the private, what your thinking has been, and how that has impacted in terms of what you will be recommending for us to consider.

Dr. LEE. First of all, on the direct funding of the residencies, the direct graduate medical education fund, we looked at the current salary payments; we projected forward, making an estimate. Currently, it is about \$55,000 per resident. That includes the salary of the resident, the fringe benefits, and the additional cost of the faculty supervision. It does not include an indirect cost in addition to that. And it was on that basis that, as with physician payment in the Medicare program, we felt that we should move toward a national average prospectively determined, rather than on a cost basis which, as the people who have looked at this have told us, is very, very difficult because of different accounting methods to actually make a cost-based payment.

So we thought it was better to establish a prospective payment. You would then with that salary level—there are some that are significantly above that, and those would gradually have to be reduced; they would not be reduced abruptly—there would be an additional factor there in that, for example, the cost of living costs a resident more in New York than it does certainly in Iowa, probably in Kansas City, maybe somewhat less, not a great deal less. But

those costs would be calculated.

That was the approach we used to figuring the amount of money that would be needed with the number of residents, with the cost

per resident.

On the academic health center fund—and first of all, when that fund is established, the Medicare direct funds would go into that new fund. There would be an assessment on the plans, on the alliances, for the additional funds from the private sector. And as those come in, those would then establish the fund, so that by 1998-1999, that fund would be fully established, and at that point it would be \$5.8 billion.

The second fund for the academic health center would flow from the indirect medical education funds initially, that portion. Now, in the budget proposals that have been made by the administration, there has been a reduction proposed in the current indirect medical education in Medicare funds, and ProPAC has a somewhat different position than the administration about the degree to which that fund can be reduced, so that is an area where there is cer-

tainly some disagreement with our proposals at the moment.

As we looked at that, we felt that when you cover the full costs of care through the plan, so that these hospitals do not have bad debt and charity care, the proposal that we have put forward would fund adequately these additional costs. And I would say there is an area where we probably have the largest disagreement in the conversations we have had with people in the academic medical centers. They believe we have underestimated those costs. One of the critical factors in making those estimates is what is the inflation factor that you calculate into the base through the year 2000. Those are the kinds of issues we have to look at very carefully, and we will be reviewing that. This is certainly an area that we will want to be working with you closely on.

On the fund for graduate nurse education, a similar policy will be followed as with the graduate medical education. The \$200 million proposal is our best estimate of what it will take, because we do believe that those programs need to be significantly expanded. As opposed to the ones in graduate medical education, where we think over time there can be some reductions in numbers, we think these clinical nurse specialist and midwifery programs and some of

these others need some expansion, so that is the reason for that

\$200 million level.

That basically is the approach we have taken. We have had an outside group working with us. We have had Jerry Anderson at Johns Hopkins, who is probably one of the leading scholars in the field, assisting us in developing these calculations.

The CHAIRMAN. My time is just about up. We will be glad to work also on the transition period and whether that is suitable or

not.

Dr. LEE. Yes, that is critically important.

The CHAIRMAN. We really have to hear from the educators and the academic centers and others on that, but we will be glad to

work with you.

Of course, we can remind ourselves that—and it varies in terms of great medical centers—but the taxpayers are paying a great deal in terms of graduate medical education now. It is the taxpayers. You might refresh my recollection, but I believe that as a generalist, it is well over 50 percent. I do not know what it is in particular kinds of schools, but it is up in that range. So obviously, they have a general interest in how our medical personnel should be trained, because it is the taxpayers' money that is going into underwriting a good part of this education.

Dr. Lee. It is either through the taxes and Medicare or Medicaid, or the funds that we pay when we pay for an insurance premium. So it is coming out of the taxpayer's pocket or the wage-earner's pocket, and that is basically paying for graduate medical education;

that is absolutely right.

The CHAIRMAN. Senator Kassebaum?

Senator Kassebaum. Thank you, Mr. Chairman.

Dr. Lee, in laying this out, though, why is it necessary for the Government to determine the physician work force in such an exact manner? As I understand it, the committee or board would determine the residency needs in 80 specialties and then distribute those positions to different locations. For instance, wouldn't it be possible that the board would determine if Salina, KS would continue to have a certain type of residency program.

Dr. LEE. Let me just deal with the general question first. Current policies of the Federal Government, particularly Medicare reimbursement policies, which have driven other reimbursement policies, have significantly contributed to the current maldistribution by specialty. So we have a policy now that is driving work force in

the wrong direction.

The reason we have an oversupply of medical subspecialists is because in teaching institutions—in the department of medicine, for example, at UC-San Francisco, a significant portion of our income in that department was generated by cardiology and gastroenterology, and having residents to meet those needs in part—there was also education, there were also opportunities—but those reimbursement policies were and would continue to have a very significant influence.

So that I believe there is a role for the Federal Government. Then the question is: Is the proposal that we have made to create this national council that would make decisions in an open way an appropriate mechanism? My own view is that it would be. It would

not determine whether there is a residency in Salina or in Boise, ID. You would take the existing residency distribution; you would look at the quality of those programs. If you look at the number in primary care, and if you go to 110 percent, let us say, over a 6-year period, you would not have to increase the number of residencies in those specialties but very little to achieve that 55 percent goal.

You would have to reduce significantly the numbers in some subspecialty areas and some other specialty areas. And that, you would do based, hopefully, as best you could on the quality of those residency programs. You would have to look at some other factors.

A number of minority groups have said to us that they have not had the opportunity to enter specialty training in the way others have been able to. That needs to be looked at. We want to have a system that is fair to every qualified medical student to go into

the specialty that they are most appropriate for.

So that the historical patterns, the current quality and the measures—the residency review programs review the programs for quality. You would not fund any program that did not meet those standards. But I do not see this body determining that the University of Kansas needs to establish a residency in "x" location. If the needs are there, and those are determined, and they are reviewed, and they are appropriate, then those would be funded. So the decision is much more, as it is now, decentralized as opposed to being a highly centralized process.

Senator Kassebaum. I guess I am just not sure that that specificity is necessary. I support, as you know, changing the weighting in the Medicare GME to provide greater focus for primary care providers. I have tended to believe that changing the weighting in the Medicare GME, along with the increased salaries for primary care providers, would bring more medical students into this field. This would occur without us trying to be so determinate from the na-

tional level.

Dr. LEE. Well, initially, I was not in favor of this approach. I thought the market could produce the changes in the residency distribution. But as I have talked to people over the last 4 or 5 months, I have become convinced that in the first 5 to 8 years, the forces are sufficiently strong in the other direction that the market toward generalists, toward managed care and organized delivery systems is not sufficiently strong to change the residency mix. Perhaps in 8 years or 10 years, we could sunset this mechanism, and the system would work without it. I would think that we might be able to do that. But I think that in the interim, at least I have become convinced that this approach is necessary.

Now, clearly, this is a question this committee will really have to decide, but you might want to talk with some others and some other witnesses who will be testifying. Some of the economists have been looking at this, and we have been talking to them, and more convinced me that the market is not strong enough to change the

patterns quickly enough.

Senator Kassebaum. Thank you very much, Dr. Lee. My time is up.

The CHAIRMAN. Senator Simon?

Senator SIMON. You were ahead of me here, Senator Wellstone.

The CHAIRMAN. We still follow seniority.

Senator WELLSTONE. I have been protesting this ever since I came here.

The CHAIRMAN. I know; I used to, too. [Laughter.]

Senator WELLSTONE. And for those of you who are laughing, we have had the exact same exchange on this issue, and he always says that.

The CHAIRMAN. Paul is moving up a little further each time.

Senator Simon?

Senator SIMON. Thank you, and I will take advantage of my se-

niority here.

First, I applaud the general direction of trying to move toward the family practice, the general practitioner. I am not clear on how we get from here to there yet, and I agree that, as Senator Kennedy has mentioned and you have mentioned, our present system has generated and encouraged the specialties rather than encourage the family practice.

How many members will be on this national council on graduate

medical education?

Dr. LEE. We will probably have 12, 13, maybe 15 members.

Senator SIMON. And they establish these national goals. And is

the 55 percent in the statute, or is that just——

Dr. LEE. That would be determined by the Congress, to decide whether it should or should not be. My own feeling is you do not want to fix it in statute, although that is clearly possible, because it may be that in 5 or 8 years, we say it ought to be 60-40 or 50-50. So that that would be looked at by the national council on a continuing basis and judgments made.

We would set a goal, move toward that goal, and then you would determine whether that is appropriate, based on what the needs

are.

Senator Simon. Where did we come up with the 55 percent num-

ber?

Dr. LEE. Two things. First of all, I would say there is more of a consensus, looking at the distribution in other countries, looking at the distribution in managed care plans, that if you exclude obstetrics and gynecology, about half the physicians, and in most other countries, more than that, are in generalist fields—general medicine, general pediatrics, family practice. The 55 percent comes with the addition of obstetrics and gynecology, because many women use obstetricians as their primary care physicians. So that even though they do perform a fair amount of surgery, they still function in that way, so they were included, and that then increases that figure from 50 to 55 percent. But it was more of a consensus. There is no analytic study that says this is the exact figure that you should have.

Senator SIMON. I understand. And then—and this is a little bit following on Senator Kassebaum's question—how do we get to the 55 percent? How does this council work to move there? It is not

clear to me.

Dr. LEE. It is a critical question because, as Senator Kennedy pointed out, the transition is really critical. And what we have proposed in the bill is that it would be 55 percent by 1998. Now, in

the discussions we have been having subsequent to that, many peo-

ple have said you cannot get there that quickly.

If you have currently, as we do, 135 percent more residency positions than we do U.S. graduates—you have about 17,000 U.S. graduates from allopathic and osteopathic medical schools. We have 24,000 first-year residency positions, and then of course, those go on, second, third, fourth year. And with that large number, to get to 55 percent, we would have to significantly increase the number of primary care residencies in family practice, general medicine, obstetrics and pediatrics by 1998.

People have said to us that is not feasible to do that that quickly. In the bill, we are saying that the council should adjust the total number of residencies to some relationship to the graduates of U.S. schools. We did not set a specific figure. Others have said, and a number of outside organizations have said-and I think Senator Rockefeller has introduced legislation and Congressman Waxman—

that it should be 110 percent, the total number.

Now, if you go to that figure slowly, and if you go to this 55-45 more slowly than we have proposed, then you can achieve that

without too much disruption in the training.

People have been saying to us since the bill went in that what we have proposed, we could get there, but it would be very disruptive to do it that quickly. So this is an area we think we need to have conversations with this committee and with committees in the House, to decide what is the right mix over what period of time and then what should the aggregate number be. Those would be decisions that clearly, Congress would make those basic policy decisions and might then give the authority to the council to evaluate it on a continuing basis.

Senator Simon. I guess my instinct is that we ought to make the general decision that we ought to be moving more toward family practice, but whether it is 55 or 58 or whatever, that ought to be left to the council, and we should not get into that kind of deter-

mination.

Dr. LEE. Yes. I think that is a very important question, and then the aggregate number is another one that the direction might be set, which we have proposed in the bill, and some others have proposed setting the limit in the bills. Those are clearly the big questions on how the council functions and what the goals should be.

Senator SIMON. I thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Simon.

Senator Jeffords?

Senator JEFFORDS. I have no questions, Mr. Chairman.

The CHAIRMAN. Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, thank you.

Dr. Lee, thank you very much. I was just reading your statement, because I came in late, and I apologize for that. I appreciated the first page of the statement which talks about the importance of public health agencies turning their resources and expertise to their original role of protecting the health of communities and removing barriers to medical care. I just want to say that if in fact whatever comes out of health reform can help us do that, that is really a very important objective. I know your personal commitment to restoring the value of and the resources for public health in our communities, and restoring some sense of community response to these health needs. So I wanted to endorse that, even

though that is not the purpose of this hearing.

Dr. LEE. We also see, Senator Durenberger, a very fundamental change in the role of health plans with capitated payments. We believe the plans will be much more involved in prevention and in fact achieving public health objectives like immunization, through the plans, because of the incentives that are in capitated systems. We are already seeing that happen in a number of the plans.

So I think the partnership between the public and private sectors in that regard is going to be very important in terms of achieving the goals for Healthy People 2000, for example.

Senator DURENBERGER. I appreciate that. With regard to medical education and the person-power issues and so forth-and I regret very much not having heard the questions asked by my colleague from Kansas, who is the author of a bill on this-I must ask you to help me understand. As we reform the health care system in this country, it is my understanding that we, the politicians, are trying to change the incentives in the whole system; that for the last 30 years, the incentives have been for the providers of care to do better, do more, and they would get financially rewarded. And they have done all of those sorts of things, the end result being that the cost of all of this is now a critical problem with regard to access.

So as I understand the reform in this system, whether it is insurance reform or delivery system reform or whatever it is, we are trying to change the signals to reward better or more, but for less. In other words, productivity, try to do it better, and so forth. And I appreciated the President's emphasis last night on the private sector, the employer's role, and things like that. So we changed the

My question is in effect, having changed the signal, and having changed, hopefully, on a community by community basis, the way health plans, integrated with providers of care, are actually delivering health and medical services, how is it that we can predict, or the Government predict, how many of what we actually need on a

community by community basis?

As I have watched my community of the Minnesota area develop, we have moved from the subspecialties in the direction of primary care. We have done that at the M.D. level, and we have done that with the non-M.D. professional. We have raised the value of the dollar remuneration of the primary care physician because they are, quote, "much in demand," so they are making money now that they did not make before.

What I am saying to you is that if you let a market evolve in response to need, this mix of people and skills that is necessary to meet this set of needs is going to vary from one place to the other, and the mix of specialties and primary care and non-M.D. and so

forth will change, and I am assuming it will also evolve.

So my question is why the tremendous emphasis in your proposed policy on protecting institutions, on determining which programs are to be funded and which institutions will get rewarded, and on determining what are the needs in a given area and how many residencies we ought to have to meet those needs?

It sounds to me like it is the same old thing, and I do not mean this to be critical, but only inquisitive. It sounds like the same old system is going to get perpetuated—five or six academic centers in Boston, seven of them in Philadelphia, and on and on and on, very few west of the Mississippi.

Help me understand.

Senator GREGG. What is wrong with that? [Laughter.] Senator DURENBERGER. Help me understand why.

Dr. LEE. Yes. On, for example, why not simply let the market function to deal with the problem of graduate medical education—

Senator DURENBERGER. Not just that—and why not take down some of these licensure barriers, you know, that insist that we use

expensive care inappropriately.

Dr. LEE. I think there are two issues. One is will the market do it, or do you need some other mechanism. Initially, I did not favor this council idea but did favor letting the market work for a period of time and see if it works, and then if we need to have something,

have a fallback position.

But in doing a lot of consultation with people, it seemed that that was not in the short term going to achieve this change toward the generalist, that we needed managed care, or we perceived that we needed. Certainly, we can make much better estimates of the needs for rural areas. We know they are very underserved; we do not have enough generalists; the only people who will practice in those areas are family practitioners or generalists. And we do need to increase the numbers to meet those needs, because people who live in those areas deserve the same kind of access as somebody who lives in the suburbs or some other area.

Second, if you are going to meet those needs, and if you are going to meet the needs of the market, which is this organized delivery system market, that will differ in different parts of the country. Some plans will have more, as Permanente Medical Group does in Northern California—they hire more general interests; in Southern California, they are willing to hire more family practitioners. Some other plans want more family practitioners, some want more general internists. Some organized systems have more specialists who do a subspecialty plus a generalist role, like the Mayo Clinic.

So you will have different patterns in different areas, and this council would not determine those. Those decisions would be made locally. The decision they would make is whether you fund an approved residency from this GME fund. Those would be the deci-

sions the council would be making.

On protecting the institutions, the transition is a very difficult one. We do not want to destroy what have been some of the premier medical care, research and training institutions in the country. Now, the incentives have produced some malfunction in terms of graduate medical education, but those are going to change, and over time, I think the institutions will respond.

But I do not believe that where you have had institutions—like yesterday, I was at the University of Pennsylvania. I think the medical there was established in something like 1730. They developed the first teaching hospital owned by a university in 1870,

which really was the beginnings of what is the post-Flexner pat-

terns of medical education in the United States.

We are now under a reform that is going to be as dramatic as the Flexner revolution in medical education, and it seems to me that those kind of premier leadership institutions deserve some protection in this transition period. That is the reason the kinds of policies that we have proposed—they are not purely institutional protection; they are designed I think to really contribute to the whole system.

Senator DURENBERGER. Mr. Chairman, I know my time has expired, but I think everyone, including the people sitting behind you, know that the problems at the University of Minnesota, which Paul and I represent here, are caused in part by market forces, and they

are caused in part by failures internally.

Dr. LEE. Absolutely.

Senator DURENBERGER. And the concern is that somebody in Washington is going to decide how and where we are going to save. That is a great institution. That institution will come back. That institution is important to our community. But I just want to say I have some reservations about how a council, a committee, or something like that in Washington, DC, which is reacting to information that is maybe 2 or 3 or 4 years old, is going to decide how much we ought to put into Minnesota and how much we ought to put into something else. And I am not arguing. I am really trying to illustrate some of the challenges that we have in coming to grips with this question.

Dr. LEE. Yes, I understand.

Senator DURENBERGER. Thank you very much for your response.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Durenberger.

Senator Pell?

Senator PELL. Thank you, Mr. Chairman. I would first ask unanimous consent that my statement be inserted in the record.

The CHAIRMAN. It will be so included.

[The prepared statement of Senator Pell follows:]

#### PREPARED STATEMENT OF SENATOR PELL

Mr. Chairman, I thank you for holding today's hearing on the issue of training health personnel in a reformed health care system

No single issue is more important than ensuring that we have a sufficient supply of well qualified providers ready and able to care for the millions of Americans who will be brought into our health care system as a result of reform. This influx of patients needing early and preventive care will strain our existing providers and demand a delegation of responsibilities to qualified mid-level providers, both traditional and nontraditional.

Since maintaining the quality of our current system is a crucial ingredient in the effort to achieve reform, it is particularly important and appropriate for us to look carefully at these important workforce issues at the outset of this effort. I look forward to working with you, Mr. Chairman, and with our colleagues on this committee to ensure that workforce issues will be addressed early on.

Senator Pell. To follow up a little bit on Senator Durenberger's point, if this plan goes through, as we trust it will, there will be a tremendous influx of patients needing early preventive care, and it is going to strain the resources that are presently available. I think that the responsibility will fall to mid-level providers, both traditional and nontraditional, and I would like to know, Dr. Lee, having the regard I do for you personally, what your thought is about the greater use of nontraditional suppliers, not only podiatrists and osteopaths, but even some of those who are further out, like naturopaths, who give a base of health which is more likely to prevent disease coming afterward, and the dollars spent on the prevention will be returned tenfold.

Dr. LEE. Certainly, the osteopaths are mainstream, as are the allopathic physicians, and many of them, of course, are in primary care specialties—as are podiatrists, also, very mainstream and very important in terms of prevention, particularly, for example, for patients with diabetes, who require very careful attention to foot care.

In the plan, what we are proposing is a significant expansion of nurse practitioner programs and physician assistant training programs. Hopefully, they would then be working as teams in the care of patients, and in preventive care particularly, or the routine management, let us say, of hypertensive patients. We know that nurse practitioners can do very well in those settings, and there are a number of other areas where the clinical nurse specialist would function very well as a member of a team dealing with a large number of patients. And we believe that in terms of particularly access to primary care, they would be very important.

For those practitioners who are licensed in a given State and are delivering—and there is some controversy around the restrictions, for example, on nurse practices in States—we would propose that they be permitted to do those things that they are qualified to do.

Moving beyond that into some of these other areas, we did not envision the plan moving at the moment beyond those things that are really traditionally within what is a very wide spectrum of

medical care or health care.

Those are issues that certainly can also be examined. There are a large number of people who do consult with other practitioners—that is, currently, they are not included within the plan. We did not make a detailed list of which practitioners would be included, but one State might license practitioners; if they re providing services, and a plan contracts with them, they could be in a plan. But they will have to be in a provider organization or in a plan in order to participate in the Health Security Act as it is currently envisioned.

Senator PELL. Thank you very much, and we hope you will keep

as wide open an eye on this as possible.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Pell.

Senator Gregg?

Senator GREGG. Thank you, Mr. Chairman.

Just to follow on on the questions asked by Senator Simon, I am reading the statute, and it is pretty specific in the statute, 55 percent, at section 3012(b)(1). By statute, we are going to say that 55 percent of the people who are eligible for these programs have to

be enrolled, as you mentioned, I guess, in the year 1998 in the primary care area. And then the statute really goes on to make it very clear that the council is going to have just very significant authority in deciding who practices what specialties as we go into the future. And of course, that is the intent, obviously. It is a top-down approach. But I do think it has some perhaps unintended con-

sequences that I would like to discuss.

It creates an atmosphere almost like an NFL owners meeting when this council meets—they are going to pick the franchise, and the franchisee who loses, they are not going to have the doctors in their region of the country, or they are not going to have that specialty practiced in that teaching hospital, and that teaching hospital or that region of the country may want to have that specialty, and that will be gone. So it is really going to create tremendous value, not only economic but social value, being in a region being determined not by the marketplace within the region, not by the social policies of the region, but by this NFL owners' board of health care within the national council. That is one clear consequence which may or may not be intended, but it is an absolute

consequence.

Another unintended consequence that worries me—and maybe it is an intended consequence—is what happens to the students. The capacity to go into a specialty is obviously going to be curtailed dramatically. What sort of effect does that have on behavioral decisions of students choosing first to go into medicine-and we have always traditionally had the best and the brightest in our society go into medicine—is that individual, looking at his or her career path, going to say, "Well, if I choose medicine, I lose control over my life because my capacity to choose what I want to do in medicine is going to be determined by the fact that the realm of decisionmaking that I will have available to me is significantly proscribed by this NFL owners' committee," and therefore maybe the best and brightest decide, or a percentage of them decide, that, well, because I want to have my own rights as a citizen to choose my path of professionalism—and granted, I am willing to face the marketplace on that choice. I will take my risk in the marketplace. Maybe I can make money, and maybe I cannot make money, but I want to be a cardiologist, or I want to do some other type of activity, but I will not be able to make that choice because the structure is going to be there that will not allow me into that area.

Will that mean that some students will not go into medicine that we would otherwise expect would go into medicine, and we will therefore have a form of rationing which will be a very sort of sub rosa form of rationing, and the quality people will decide not to

choose medicine?

And does it also mean that once in medicine, the individuals will opt for some other sort of activity than hands-on care; that they will say, I do not want to be in primary care, and I cannot get into the specialty I want to get into, so I am going to go out and do something else with my medical degree. There are a lot of other opportunities that I presume would be outside of this.

So I guess that is my question, convoluted as it may be. The unintended consequences of this huge, top-down control that you are instituting here, which you were initially not, as you have said, re-

ceptive to, but have been talked into or have become supportive of, seem to me to be dramatic, and I suspect I am only anticipating just a small percentage of the iceberg here. But you are talking about a lot of behavioral impact when you start limiting the choice

of people and their profession and professional career.

Dr. LEE. There are multiple factors that influence a medical student's decision to enter a specialty. One of those is the influence of the faculties in the medical schools, and where you have had faculties that are heavily subspecialty-oriented, a much higher percentage of those students go into subspecialties and not into general specialties than in other schools.

A number of the public institutions—and we consider the University of California, at least San Francisco, but the others-to be among the premier medical schools in the country. We have a much higher percentage of our students who go into generalist careers than students who go to some other equally good institutions. The decision that the board would make or the council would

make is not who can go into a particular residency. That is decided by the people who run the residency program, just as they decide today. They accept some and may reject others. There is a matching program. People apply. The programs make the decisions. The council would decide which of those residency programs is funded based on these various factors that I have indicated earlier.

In terms of student choice in the future with respect to careers in medicine, my own view is that medicine remains one of the most attractive professions. In the future, when everyone is insured, and a physician can do what is appropriate for each patient, not based on economics, which is necessary now in many cases, but based on the needs of the patient, it is going to be an even more attractive

profession.

We have not seen in other countries such as Canada, England, France, Germany, that regulate the residencies—they determine the mix of residencies—that there has been any decrease in the

quality of people going into medicine in those particular countries. So that I believe that the choices, the generalist careers, general medicine, general pediatrics, obstetrics and gynecology, are extremely attractive specialties. We will much more level the incentives now. The incentives now to go into some of the subspecialties, particularly procedure-based subspecialties, the economic incentives, have been added to the professional incentives and to the environment in particular institutions, and I think have driven more people in those directions who would just as well and just as happily practice in a more generalist role. But the decisions would not be made by the national council. They would be made at the local level by those who are making the decisions today.

Senator GREGG. Well, to go back to rather strained, perhaps, analogy, if the NFL picks a town for a football team, then the players can play football there, but if there is no team in the town, then the players cannot play football there. And under the procedure that you are setting up here, in a lot of towns, there are not going to be any teams; there is not going to be any specialty training in a number of categories, or it will be significantly proscribed because they will not have been deemed eligible because the emphasis will be on creating the 55 percent. So I think it is a very narrow

view to say that that is not going to control the availability of people to get into these specialties.

Dr. LEE. Well, it is controlled now. I mean, there are a limited

number of residencies in these fields now.

Senator GREGG. Well, of course, there are; we all accept that. The proposal you are suggesting is a radical expansion of the control, centralized in a very small group of people sitting here, theoreti-

cally, in Washington, or maybe someplace else.

Dr. LEE. You see, I think when Congress set the policies for Medicare, they set the direction of and had a very significant impact on residency training programs and the payment for those specialties, and in fact had a very, very significant influence on the current distribution.

So it is not as if you are not going to influence it one way or another; it is what mechanism do you choose to use. As Senator Durenberger said, the incentives in the system are now producing a physician supply that contributes to rising costs, is not well-distributed geographically. I think there is a broad consensus outside that there needs to be a significant shift toward this 50-50 or 45-55 mix.

Senator GREGG. I agree with that. We have an overabundance of people in a variety of specialties.

Dr. LEE. It is how do we do it.

Senator GREGG. And Medicare may be driving the process, but they are doing it through, at least marginally, the marketplace because they are reimbursing on the fee-for-service basis, whereas this is just going to be a group of people who are very arbitrarily, really—I mean, I am sure they will not consider it arbitrary—but because they are just a small group of people, will be deciding winners and losers in this arena. And I would rather see us bring a few marketplace forces in to make that decision and get to the bottom line goal, which is to have more primary care people and to change the mix of specialists, which we all know-and Dr. Wenberg does come from my State, so I am familiar with—so I think we want to get to the same end line, and it is just how we get there.

Thank you. The CHAIRMAN. Senator Wellstone?

Senator Wellstone. Thank you, Mr. Chairman, finally.

The CHAIRMAN. We can hardly wait to hear what you are going

to question on. [Laughter.]

Senator Wellstone. It is not earth-shattering. To start out with a little drama, I would like to have my statement included in the record.

The CHAIRMAN. Should we vote on that? [Laughter.] It will be in-

cluded.

[The prepared statement of Senator Wellstone follows:]

#### PREPARED STATEMENT OF SENATOR WELLSTONE

Mr. Chair, I appreciate your calling this hearing today to discuss the vital issues of training health personnel in the context of health care reform. We must give the issue of funding for academic health centers, and training for doctors and nurse professionals, our fullest attention. This is an illustrious panel, and I look forward to hearing their testimony.

Physician training must be designed to meet our needs. Some 80% of our doctors go into specialty care, each of them generating half a million to a million dollars in charges a year, while millions in underserved rural and inner city areas can't find anyone to take care of them. We need to learn how to motivate and support young medical students who want to practice primary care in areas where they're needed. I proud to point to our fine medical school in Duluth, Minnesota, which has been nationally recognized by Hillary Rodham Clinton and many other health care analysts for its success in recruiting and training young professionals who are dedicated to working in the kinds of rural areas that typify Minnesota.

In nurse training, also, Minnesota's Health Right legislation forged new ground in establishing loan forgiveness programs to

help educate nurses and advanced practice nurses.

I strongly support the direction of the Health Security Act to reconfigure and rationalize our current system of reimbursement for direct and indirect costs of graduate medical education through Medicare, and to increase the number of primary care providers we educate, while continuing to support our academic health centers. These adjustments are made possible by the bill's commitment to universal coverage and a regular source of funding for the health care of every person.

At the same time, I would like to take the opportunity to emphasize what Assistant Secretary Lee and several other speakers will be addressing today. It is critical, in discussing health personnel, that we recognize the importance of a range of primary care and

non-professional caregivers.

I am submitting for the record the testimony of Kristen Gardner and Dr. Mary Beth Love of the Community Health Worker Training Program at San Francisco State University. Worldwide, primary health care delivered by community health workers is the simplest, safest, and most inexpensive medical and public health measure providing direct and essential health care to underserved populations. Their skills range from providing information on how to access existing services, to providing case coordination and health education on prevention and primary care. They are often the best link between a community and its health care institutions. Their training may last from six weeks to a year. For some, this career path is a way into the work force. For some health professionals, it is an added skill.

The health care reform bill I introduced, the American Health Security Act of 1993, S. 491, calls for increased attention to training community health workers and other mid-level health workers. The San Francisco State program is an excellent model in improving the level of culturally and linguistically appropriate health services, as well as employment opportunities, available to disadvantaged communities. I believe this an important direction for our health personnel policy to explore, particularly through a body such as the proposed National Institute for Health Care Workforce

Development.

In addition, we must consider the curriculum for training health personnel. At every level, health care workers can provide life-saving services if they are educated to identify and refer victims of domestic violence. The Early Detection and Preventive Health Act, which became law just last year, incorporated a bill I introduced that would fund just such training for health care providers. I look

forward to encouraging the implementation of that law.

Senator WELLSTONE. And I would like to submit for the record the testimony of Kristin Gardner and Dr. Mary Beth Love, of the Community Health Worker Training Program at San Francisco State University.

The CHAIRMAN. They will be included.

[The prepared statements of Ms. Gardner and Ms. Love may be

found in the appendix.]

Senator WELLSTONE. First of all, Mr. Chairman, I thank you for the hearing. I think it is real important both to focus on academic centers of excellence and also primary care. And I wanted to tell you, Dr. Lee, that I met with a great group of primary care doctors at the University of Minnesota-Duluth that Mrs. Clinton highlighted when she came out to Minnesota. They do a really fabulous job of training doctors to go into primary care, and many of them go into rural areas. They also have a very strong program training Native Americans in this area. It was about 38 degrees below zero—that is not wind chill—but people came, and it was a really

fine hearing.

I was listening to Senator Gregg, and I have a very quick response, followed by a couple of, if you will, micro questions. At the macro level, sometimes I feel like, when we talk about the market-I mean, we are not allocating toothpaste here, or color TVs-I do not really see lots of small businesses and competitive enterprises competing against one another: in the health care field The verdict has been kind of harsh for many of our underserved communities, and as much as I hate to say it, I do not see the medical schools at this point in time, given the inevitability of a stacked deck, as you said, given the history of our policies, with all the incentive going in the opposite direction, I just do not see our medical schools and I do not see the health care in this country really focusing on the importance of primary care. I mean, we see study after study after study. We need more primary care, we need more family doctors, we need more nurse practitioners, we need more physician assistants, we need to get health care out in the community. That is front line medicine. That is the key in terms of preventive health care. That is the key in terms of bringing costs down. That is what people and communities are asking for. And quite frankly, I do not see the market verdict moving in that direction.

So I do not see it as being so top-down. We are all publicly accountable. We decentralize the decisionmaking, and I think that is

the direction we need to go in.

Now, two micro questions, now that I got that off my chest. One is, with the strong support of Senator Kennedy—it was a bill that we did together and then, ultimately, it became part of the CDC program, with a little funding—we focused on training health care providers to identify family violence when it walks into the hospital and walks into the clinic. That is a really strong area of interest and commitment on the part of myself and on the part of my wife Sheila and I know many others in the Senate and the House.

I wanted to ask you whether or not you know of existing programs, because it is quite often where a victim of family violence,

be it a woman or a child, sometimes a man, but more often women and children, feel most comfortable in really saying what has happened to them. Do you know of any medical school training programs where this is built into the training?

Dr. LEE. Well, I think, Senator Wellstone, that the pediatricians have probably done a better job in this area. There are a number of hospitals that have centers to deal with problems of child abuse, and there has been much more attention in the curriculum around identifying children who have been abused than the adult family

abuse, spouse abuse, or elder abuse.

We can certainly determine that. I do not have it in my head and cannot identify it, but I do know that there has been a strong move in pediatrics for a number of years, and that there are a number of children's hospitals particularly that have excellent training programs in the area of child abuse prevention, early detection and prevention, interventions, that has not spread as broadly to the other areas. I think that emergency physicians are also becoming much more sensitive to this area and are in their residency programs, I think, beginning to get trained. I cannot cite at the moment, but we will see if we can provide you with some information on that.

Senator WELLSTONE. And I wonder if we could not work together on that, because I know that we have received strong support from the American Medical Association, and I was delighted to have their support. And I think in travelling to Minnesota, people in the medical profession broadly defined, caregivers, providers, are ready for it, and it is really of epidemic proportion. So I wonder if I could not work with you a little more on that, because I believe it could

be incorporated more into the actual medical-

Dr. LEE. Alcohol abuse is very often associated with that, and that is another related area.

The CHAIRMAN. On that point, would the Senator yield?

Senator WELLSTONE. Certainly.

The CHAIRMAN. Just anecdotally, we have a program that is supported by a foundation and run by Carol Sousa in Boston, and it is to detect inappropriate behavior by boy students at early ages, and to begin to give them some help and assistance. It has basically been stimulated by concern over violence against women. Generally, no one gets into that system until they have actually violated the law, committed some kind of crime. So she runs a very interesting program, and I will send you both a copy of her testimony.

Dr. LEE. Good, good.

Senator WELLSTONE. I would be interested.

The CHAIRMAN. It is very interesting. What they try to do is detect inappropriate behavior even starting at kindergarten and the first, second, third, fourth grades. They have had remarkable success in identifying those individuals and trying to give them help and assistance, and it is really a very interesting program.

Senator Wellstone has put his finger on something that with very limited resources in these areas of preventive health—this is really an extension in terms of the range of preventive programsmay be of some interest, and we ought to try to think about how this fits into the public health programs and some of these other areas.

Senator Wellstone. Exactly, exactly.

Dr. LEE. Well, the program emphasized last night in the State of the Union Address violence and the prevention of violence as it relates to health care. I think we do need to look to see where we can fit this in.

Senator WELLSTONE. Right. Thank you, and I would like to work with you on it. I would be very excited to do that, and with Senator

Kennedy.

Dr. LEE. I would be very, very happy to do that.
Senator Wellstone. The other thing is I just want to know where the training—and I hope I will be able to stay around; I have some questions on nursing later on-but where does the

training for community health workers fit into this?

Dr. LEE. There would be two areas where this would be potential. One is in the money going to the Department of Labor. This would be for retraining of people who may have been displaced as we move toward more managed care and downsizing of particular institutions, and training people for that; that is an important ele-

The home health community-based long-term care provisions will provide more training for people in community-based deliver systems, and within the public health training authorities, we have been doing it more at the professional level than at the community level, but we would certainly look at that in that authority. And

you may want to put some more specific language in there.

Senator WELLSTONE. Two final points. I have run out of time, but the two final points are that, of course, when we talk about primary care broadly defined, I do not think we need to focus just on family doctors. I think there is a real role for people in retraining. My question is—and you know what my question is going to be is there a stable source of funding for this?

Dr. LEE. The administration has committed itself to working with the Congress and with the leadership to identify a stable source of funding for all the programs in Title III of the Health Security Act. Those go well beyond some of the things we have dis-

cussed.

The GME fund, the nurse graduate medical education fund, and the academic health center fund are basically entitlements already, because the funds come out of the Medicare pool and out of the funds going to the alliances, so those are in fact entitlements. But the rest of the programs, or the programs in Title III, that has not yet been worked out, but there is a commitment to do that, and we hope that that will be accomplished fairly soon.

Senator WELLSTONE, Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. I would just underline what Senator Wellstone has said with regard to these programs, because as he and others have pointed out, we will be glad to get the card-it will never be taken away from Americans-but we want to have a delivery service that is viable, whether it is in the rural or urban areas. There is obviously great interest in the membership of this committee on a variety of different issues, but certainly that is important.

I want to thank you very much again.

Dr. LEE. Thank you.

The CHAIRMAN. Your testimony has been very helpful.

We will leave the record open for members to get their questions in by the end of the week. This is enormously important, and we will ask you to respond to those.

Dr. LEE. Thank you, Senator Kennedy. The CHAIRMAN. Thank you very much.

We would like to invite our next panel of distinguished witnesses to please come forward. Dr. Dick Nesson is the president of Brigham and Women's Hospital in Boston. I am delighted to welcome him. We were classmates many years ago, and he has been one of our great health administrators as well as a thoughtful commentator on health policies.

Dr. Bondurant is chairman of the Association of American Medical Schools and dean of the University of North Carolina Medical

School at Chapel Hill.

Dr. John Naughton is dean of the School of Medicine, State University of New York at Buffalo.

We will start with Dr. Naughton.

Senator DURENBERGER. Mr. Chairman, may I interrupt?

The CHAIRMAN, Yes.

Senator DURENBERGER. Your Republican members are required to be at a lunch meeting at 12:00, and I just want everybody else to know that we have decided to sort of violate the rule and stay here, at least through the testimony of these witnesses.

The CHAIRMAN. What are they deciding over there, anyway? Are

you going to tell us?

Senator DURENBERGER. It is not a decisionmaking lunch. But I just wanted to in advance explain to you, Mr. Chairman and to the others—

The CHAIRMAN. Maybe Paul Wellstone and I ought to go over and monitor that for you. [Laughter.] Well, I appreciate that very much.

We tried to accommodate time pressures.

All the testimony will be included in the record in full, and if you could make some brief comments, then I am sure, as you can tell, we will have some questions.

Dr. Naughton?

STATEMENTS OF DR. JOHN NAUGHTON, DEAN, SCHOOL OF MEDICINE, STATE UNIVERSITY OF NEW YORK AT BUFFALO, BUFFALO, NY; DR. H. RICHARD NESSON, PRESIDENT, BRIGHAM AND WOMEN'S HOSPITAL, BOSTON, MA, ON BEHALF OF COALITION OF MASSACHUSETTS TEACHING HOSPITALS; AND DR. STUART BONDURANT, DEAN, SCHOOL OF MEDICINE, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL, CHAPEL HILL, NC, ON BEHALF OF ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Dr. NAUGHTON. Mr. Chairman, first of all, I appreciate the opportunity to present to you some of the role of Consortial Governance in GME that we are testing in Buffalo, NY and to disclaim any ownership of a franchise.

We have been in the consortial model of governing our GME in our Western New York region of eight counties for about 10 years. That organization began with the schools of dentistry and medicine at the State University, together with our eight teaching hospitals, and it came together in order to respond to the initial changes the Accrediting Council on Graduate Medical Education made in 1982, where a single institution of record was required for having these programs.

This institution is composed of the eight and now nine teaching hospitals in our region, all of the residency training programs, the two schools, and operates as a shared cooperative governance in

which each institution has one vote.

I have reviewed the report that is being submitted on the fourth annual COGME report, and many of the things we are doing are in parallel with that, so I will give some comparisons where appro-

priate.

We have very simplified governance. The administrative committee, which acts as an executive committee, is mainly the CEOs of the organizations, and one representative of our program directors, and one resident representative. There is a program directors' committee, which evaluates and determines the nature of our programs, and the residency committee, and they work in concert to carry on our effort.

In 1989 and 1990, as a result of the commission that was created by Governor Cuomo on graduate medical education in New York, and then subsequently the creation of the council, our consortium agreed to respond as a demonstrate site to see how to meet some

of the recommended changes that came out of that council.

So we have committed as an organization and a community to distribute 50 percent of our residency training programs to primary care, hopefully by 1995 or 1996, to encourage and hopefully achieve a minimum representation for minority and socially under-represented groups of 11 percent, and to focus more on primary care and chronic care as it applies to the elderly—we have a 17 percent geriatric population in our region—and to chronic care of those

children who become adults.

As a part of that, there has been experimentation with pooling of funds, and to make that happen, we have had to bring our local payers together, all of our non-Medicare payers in our region, and they have participated by contributing a pooled fund of about \$3 million a year to stimulate new projects in our region. These are created through enhancements and brought back from the hospitals to this pool. In that way, we have been able to develop some new initiatives in primary care and outreach and to focus on where we want to go.

In addition, the hospitals have pooled a portion of their indirect medical education funds from the non-Medicare pool, and that has

stimulated also some new programs in primary care.

We have also pooled all of the residents' salaries in our region, so that one corporation pays all the residents, and therefore there

is a common standard salary and fringe benefit.

We still deal with the same problems that the reimbursement system brings, in that none of these funds come directly to the consortium; they come through the hospitals and then into it for repooling back out. One of the proposals that was made by New York State Government was to pool the IME funds to stimulate the weighting and incentives of primary care, but the regulations do not permit that, so they still come through the hospital system for these activities.

I would like to say that during this period, I think we have ad-

I would like to say that during this period, I think we have addressed and are trying to deal with some of the issues that people think are important—one, cutting the cost of growth in graduate medical education, and we have agreed to do that by having a cap for our region. Our cap is 788 positions, and that is about 25 per 100,000 of our population in the region, so we are a little below the national average on distribution of residents already.

Our current distribution of physicians to primary care fields in the current definition in New York—internal medicine, pediatrics, and family medicine—is 42 percent. We hope to achieve that level of distribution this year, and then if that is the case, we will work on shifting 8 percent of the other pool to accommodate reaching the

50 percent goal by 1995 or 1996.

We have reached a pool of 9.5 representation for minority and socially disadvantaged. Our goal, as I told you, is 11 percent, so we

still have to work on that to make it happen.

We are participating, as all of the medical schools in New York are now, in the IME up-weighting that was legislated 2 years ago. Currently, primary care residencies are given a weight of 1.5, and surgical specialties are given a weight of .9. Obviously, that is an incentive to have the faculty in the community change the nature of the programs, and we are seeing that being very effective in our organization, so as an incentive, we think that that is beneficial.

As I said, we have been a model in new York State for consortial organization that has been recommended by the council to all of the regions, and therefore we have gone through some of the trials and errors of what are the advantages and disadvantages of consortia, and I think from our point of view, anyway, from a regional planning of graduate medical education, to meet both the schools' needs and the regions' needs, that this form of governance has proved to be a very valuable form. It brings to the table not only the educators, but the hospital management teams, the payers, and obviously, consumer input as well. So we have entered into that problem of how do you bring a community into health planning, graduate medical education, and yet keep control so that quality and management of those programs lies with the university.

We have had some rather interesting outcomes that are positive. One is that as a result of this commitment, our primary care chairmen—medicine, family medicine and pediatrics—together with our social and preventive medicine chairmen, have formed a unique center that we call the Primary Care Resource Center. This is integrating and preventing duplication of parallel program development in all three disciplines, so cross-fertilization and exchange, where reasonable, is occurring, and I think that is very valuable.

Obviously, we will change our medical school curriculum, and to that end, we hope to be one of the final Robert Wood Johnson finalists for the Generalist Initiative Awards that will be known this

summer.

We feel strongly that the issues that have been raised here by you and Dr. Lee need to be addressed. Academic health centers of all forms will need transitional help. We are talking about major reform in how our hospitals perform and how our training programs are conducted, and obviously there will be trade-offs in personnel and costs that have to be shifted. Tremendous damage could be done if they are not done in some reasonable way.

Obviously, students and residents need incentive and support to pay for their debts and enter these fields, particularly if they go to

underserved areas.

So in conclusion, in regard to the fourth COGME report, we are advocates of the consortial approach. We think it should be considered seriously. We are advocates of reasonable determination of how the residency programs are determined. We know that as the pool is shrunk, and it will be shrunk, that some cross-fertilization across consortia will have to occur because not all specialties will be in every medical center. We see ourselves working more closely with our neighbors in Rochester and Syracuse in later years.

We think that direct funding for the consortia is the best approach, rather than by program, but the consortia do have to be responsible to somebody. We are responsible to the New York State Council at the present time; they visit us and evaluate whether we

are making our commitments regularly.

Thank you very much for your time.

The CHAIRMAN. Very interesting. We will come back to you for questions.

[The prepared statement of Dr. Naughton may be found in the

appendix.]

The CHAIRMAN. Dr. Nesson, we are glad to have you here.

Dr. Nesson. Thank you, Mr. Chairman, members of the committee. My name is H. Richard Nesson. I am president of Brigham and Women's Hospital in Boston, but I am here today on behalf of a Coalition of Massachusetts Teaching Hospitals, to comment on the health professions work force and the academic medical center provisions of the Health Security Act and how it would affect our community.

First, though, I would like to thank the administration for placing health care reform at the top of the national agenda and to thank Senator Kennedy for his years of leadership on the issue of health care. The Senator's knowledge of the issues, his commitment to quality care, and his understanding of the special needs of teaching hospitals is not only impressive, but very deeply appreciated.

We believe that the mission of the academic health centers—patient care, research, and teaching—can only be enhanced by the passage of thoughtful health care reform legislation, and we look

forward to working with those involved in making it happen.

The administration's call comes close on the heels of significant changes in the operating environment in Massachusetts teaching hospitals. We have seen rapid penetration in the market of managed care providers, and the providers have a growing power to negotiate fixed price contracts and to tightly control utilization. At present, 80 percent of Brigham and Women's patient care revenue is derived from fixed price contracts. No longer are we able to shift costs to charge-based payers, and we are severely limited, therefore, in our ability to deal with further cuts.

The Health Security Act affords the unique opportunity to achieve comprehensive reform. We remain deeply concerned, however, that provisions of the Act would significantly affect our ability to provide the quality patient care, teaching and research that the

American people have come to expect.

I want to emphasize, however, that while we are concerned about the specific provisions, our support for the goals of the legislation remains unflagging. I might point out that the annual report from my hospital this year is structured around the President's six principles and illustrates how our work is consistent with them. We seek to work out the differences that we see and help revise the legislation, but we remain focused on the many areas of agreement. So we do not want to allow this unique opportunity to slip away.

Some of the concerns relate to the following. First, the provision for graduate medical education. The spectrum of costs associated with our academic mission makes it extremely difficult to compete in the current managed competition environment. Without adequate funding, the financial health of these very important institutions will be severely compromised. While we can and are becoming more cost-efficient, the costs associated with training the next generation of physicians must be adequately accounted for.

Our analysis shows that the Health Security Act seriously underfunds graduate medical education, and that Massachusetts teaching hospitals would lose \$1.9 billion in funding over the 5

years proposed and reduce subsidies from all payers.

The inadequacy of the graduate medical education funding is compounded by the Medicare reductions proposed to help finance health care reform. We estimate again that the same group of teaching hospitals in Massachusetts would face reductions of approximately \$1.3 billion in reduced Medicare funding. So this combination would have very devastating results, we think, and we urge that we not ask teaching hospitals to shoulder this disproportionately large share of the burden of financing the health care reform.

We are also very concerned at the bill's definition of "academic health center." We believe that the definition could allow funds intended, if you will, to go into a pool would end up in places for which they were not intended. this is clearly contrary to the purpose of the Medicare indirect medical education adjustment, which the pool is intended to replace. We urge that the bill specify that only those entities incurring the costs of treating patients be eligible for these funds.

We also oppose the bill's requirement that direct medical education funds be paid to programs "within academic health centers." This would mean that the funds would flow to residency programs, which do not incur the cost of teaching, rather than to hospitals and medical schools, which do. I just think that is amiss.

Finally, I would urge you to consider modifying the timetable for implementing the proposed residency mix of 65 percent primary care physicians to 45 percent specialists, to more realistic goals.

These are major changes, and will take time to implement effectively. We also believe that the transition funding allocated to programs losing specialty slots is insufficient and should be increased.

Finally, we believe that a chief executive officer of a teaching hospital should be included as a member of the National Council

on Graduate Medical Education.

In conclusion, I would like to reiterate that the Massachusetts teaching hospitals stand firmly in favor of health care reform. We ask that you keep our special concerns in mind as Congress debates the Health Security Act and the various health care reform proposals under consideration. The unique contributions of the academic health centers to American health care must be adequately recognized and funded, or the American health care system may sacrifice one of its most important components—a mistake that was made in England many years ago.

I thank you for allowing me to make these comments. I have many thoughts about some of the questions I heard earlier, and given my prior experience both in being active in health maintenance organizations as well as running a national primary care training program, I hope we can go back to some of those subjects.

Thank you.

The CHAIRMAN. Very good. Thank you.

[The prepared statement of Dr. Nesson may be found in the appendix.]

The CHAIRMAN. Dr. Bondurant?

Dr. BONDURANT. Thank you, Mr. Chairman.

I am Stuart Bondurant, dean of the School of Medicine of the University of North Carolina at Chapel Hill and Chair of the Association of American Medical Colleges.

I too want to thank all of you, especially those who have given up another opportunity, for being here. We appreciate this very

much.

In this setting, I would also like to claim another association, Mr. Chairman, and that is as an alumnus of the GME program of the Peter Bent Brigham Hospital, the predecessor to this, and to make the point that I was privileged to be able to change hospitals during my residency, and the virtue of having an experience in more than one institution has been one that I have treasured, and I would hope that that degree of flexibility can also somehow be perpetuated.

I too want to thank you very much, Mr. Chairman, for your leadership in the whole area of health care reform. The Association of American Medical Colleges is proud of the fact that it was 1969 when it first came out officially and formally in favor of universal coverage, and so we, too, have been in this for a long time. As a matter of fact, I testified myself in the era of the Nixon proposal,

to which you referred in your opening remarks.

The CHAIRMAN. Which side were you on then? [Laughter.] I have

been on every side of most of these issues.

Dr. BONDURANT. As a matter of fact, I was testifying for the American Heart Association, and the testimony was that no matter what you do, take care of patients with heart disease, Senator.

I would also like to express appreciation for the opportunity provided by Dr. Philip Lee to develop our thinking within the AAMC about the Health Security Act. They have given us a basis for informed opinions, and we appreciate that very much.

I would like to join—I simply cannot improve on Dr. Nesson's description of the judgment that the time is here for health care reform; the interests of all of us are in seeing health care reform succeed. We support that. I am a little concerned that our testimony may read as though it is carping at details rather than saying we

need to get on with the big picture.

The Nation's medical schools and teaching hospitals accept our great responsibility both for health care and health care reform, and given the necessary tools, we are confident that we can produce two essential products. One is a physician work force competent to take care of the health care needs of the people in primary care as well as specialties, and the second is the information or knowledge base that is the basis for all practice of medicine.

In addition to that, we accomplish a substantial fraction of the total health care of the country. Well over 50 percent of the indigent care in the country is of course delivered in the teaching hos-

pitals of the country, so our stakes are very high in this.

We appreciate the leadership of President Clinton and the ad-

ministration in initiating legislation, and we applaud that.

Specifically, we think there is an underlying policy in the Health Security Act that is of great importance to the educational enterprise, and that is the principle of all-payer support for educational enterprise. We think that is a critical underlying policy, and needs

to be preserved at all cost.

We would point out that health care reform will test the entire health care system, and the Nation's diverse array of medical schools and teaching hospitals will face particular challenges. The missions of academic medicine are highly variable among institutions and highly interdependent within institutions. Teaching physicians and teaching hospitals have inherent increased costs, making it impossible for them to compete with nontraining providers on the basis of either unit cost for service or shared risk.

Managed competition, the fundamental premise on which the Health Security Act is based, if not modified, would unravel the medical schools' entire financing system, which is based on cross-subsidization. The provisions that you have been discussing with Dr. Lee, of course, are ways of modifying the unaltered operation

of the managed competition system.

The AAMC is committed to the education of more physicians in the generalist disciplines. However, we believe that the timetable for achieving the goal is too ambitious, and we also believe, contrary to Senator Wellstone's statement, that there is evidence that both social and market forces are now beginning to operate quite substantially to address this, notably in Minnesota as one example, but I would cite North Carolina as another, and in fact the national statistics—and these are the ones that I would cite for Senator Wellstone in response to his question—are that last year there was a 7 percent increase in the number of medical students going into the primary care disciplines, the first increase in a number of years. And we must remember that the things we put in place to change those decisions have only been in place for 2 or 3 years, the most powerful things we have put in place, so we are only now beginning to see the consequences.

My own view is that it is not just market forces that is driving this. I believe these are social forces as well as market forces. We select our medical students for social responsibility, and our students do have a sense of meeting public needs as being a part of

their responsibility to the public.

So that we believe we are seeing evidence of that as well. I might say parenthetically our emphasis on that is so well-known that there are undergraduate colleges in North Carolina that now rehearse their medical school applicants in how to convince our admissions committee that they are going to be primary care physicians, because they know of the seriousness of the commitment of our admissions committee to that principle.

The AAMC does not support the GME payments being awarded directly to training programs for the reason that there are 7,000 training programs. We do support the award of the GME funds, as Dr. Nesson pointed out, to the institutions that incur the costs.

If I might also comment briefly on the question of the work of the commission in allocating the residencies, we believe too that that should be studied very carefully, and one of the additional reasons not mentioned earlier for our belief that the commission should go slowly in mandating residencies is that there is no conceptual basis or prior experience in quantifying the quality of residency programs. The accreditation process recognizes quality above a threshold, but it does not quantify quality, and there is no conceptual basis for quantifying quality. It will be a very difficult thing for the commission to conceive, design and implement a basis for quantifying the quality of 7,000 residency programs. For that reason as well, we think that that should be delayed.

The AAMC is pleased that the Health Security Act would create a separate academic health center fund. We believe that fund is seriously underfunded. We believe that the funds for GME and IME are both underfunded, and we can discuss, if you would like, as you have before, thoughts as to what would be more appropriate funds

there.

Mr. Chairman, I appreciate very much the opportunity to make these comments, and I welcome the opportunity to respond to any questions about these comments or our written testimony.

Thank you.
[The prepared statement of Dr. Bondurant may be found in the appendix.]

The CHAIRMAN. Thank you very much. I appreciate the testi-

I want to say that we will have the opportunity to go through the figures as we move along in the consideration. The fact of the matter is virtually all of the proposals on health care are going to have an impact on all the teaching hospitals. The President's is the only one that provides the kind of funding mechanisms, which you have indicated is not satisfactory, and we want to review not only the public investment and how that goes, but also the cutbacks in the private as well. We have got to quantify those to a stronger degree. But in most of the programs, the reductions under our Republicans as well in the four or five programs, all would have an adverse impact. And I am certainly impressed with the efforts that are made to try to ensure the quality issues.

The medical teaching institutions are the principal instrument for maintaining quality health care in this country, and as someone who is committed, I think we have to have the universality, we have to be able to deal with costs and the emphasis on primary care, but quality is one of those four pillars, at least in my book, and the teaching hospitals are essential in terms of that.

I would just like to ask Dr. Naughton, you have done what we are thinking of doing out there in the consortium. Just very briefly, you have been able to do it, but what have been the principal bar-

riers?

Dr. NAUGHTON. Well, the barriers are pretty apparent. The first is creating a-

The CHAIRMAN. If you could hold just a second, Dr. Naughton, I would like recognize Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman.

My question is this, and perhaps you can also respond to it in writing. No. 1, in terms of just credentialing, it fell to me in 1983 or 1984 to make sure that Medicare did finance graduate medical education, so I certainly support the notion that the best place to get a fund for medical education will be off premiums, or off the way in which we pay for our health security. But I have a serious question about the best way to translate that money into education.

Is there some reason why we cannot in effect make that money available to the students, both in the undergraduate and the graduate level, and at the intern and resident level, in the form of tuition subsidy of some kind, and let the students decide, with some help from the marketplace, as it is called—it seems to me that is the way they usually make their decisions-and the institutions themselves, both the academic and the teaching hospitals, who has the kind of program that will give them the kind of education they need to achieve their end?

Dr. BONDURANT. Let me take a crack at that. That would be a revolutionary change in the way that graduate medical education takes place. In a sense, graduate medical education now is a tuition-free operation, and it is not cost-accounted in the same way, by head counts and so on, that other educational costs are counted.

Further, there is some difference, I think, in the cost of sustaining those programs. The programs need stability—or, the cost of instability in residency programs would be even greater than the cost of instability in undergraduate programs, for example, as students flow back and forth between different kinds of disciplines. I believe I could make an argument to that effect that would be persuasive.

I understand the principle that is involved. I think the matching plan that now exists is designed to allow students to match with their preferred program, and as you know, what happens now is that nationwide, about 70 percent of the students get one of their first three choices, and something like 90 percent get one of their first four choices. So as the system now works, they are pretty well voting with their feet.

Senator DURENBERGER. Well, as the system now works, or has worked—and I acknowledge as you have that it is changing—the institutions have been making a lot of decisions for the way in which medicine is being practiced. Faculties make those decisions

by the influence they have on young people; the institution's orientation makes a lot of difference.

Dr. BONDURANT. Yes, yes.

Senator DURENBERGER. I have taken the time to look at how many primary care physicians are turned out on the East Coast, and in your area, with all due respect, it is very few. So you have given us this great medicine and this wonderful technology and these vital subspecialties, but it really is institutional education that has played a large part in that, rather than what the real needs were as they changed in our society.

And I know it is revolutionary to suggest this, and I know that it would have to be something that was evolutionary, because I agree that the rich history of these institutions, you just do not throw overboard. I mean, they have a value to the community and to the larger area. That is why I said maybe in writing or in some other institutional response besides your own experience, you could

give that just some thought and some consideration.

Dr. NESSON. There are a couple of points I would like to make in response, and they are not perfect answers exactly to the question. But the first problem with bringing people into the practice of primary care specialties relates to three or four things. One is the lifestyle is not as preferable as it is in some of the other areas.

Second, the economic rewards for people coming out with large debts has not been as good, and if you come out with a \$70,000 debt when you finish your graduate medical education, you are going to be concerned whether your salary is going to be \$70,000

or \$150,000.

Third, despite my interest in the field and the fact that I even sponsored a program in Dr. Bondurant's institution, amongst others, in primary care training, the primary care training is not as stimulating as some of the other kinds of practice. It has its own special rewards, but it happens to be repetitious. You are dealing with a lot of elderly patients. It is very important, but that is a problem, and we have not worked very well to improve that.

And finally, as pointed out, because they learn about practice in our academic institutions and our teaching hospitals, they do not get, as Rodney Dangerfield would point out, the same kind of respect within the academic center. I am not saying they do not get

it from their patients.

So we could do a good bit in fixing the way the system works. Obviously, group practice has helped us a good deal, but there is

more to be done within these specialties.

So I think we have to face up to the issue—some are within our realm. We have had a very successful training program in primary care. Everybody finishes their training in primary care and goes on to training in the subspecialties. So we have not produced the product.

I would also point out that if times are going to change, as we all believe they are, and we have such a surplus of specialists, we ought to think about retraining some of them. If we have many, many times the number of cardiologists, endocrinologists, and hematologists in the United States compared to the other places, maybe they are not all going to be as busy doing what they have done in the past, and it is really worthy, in trying to think about

the new structure of a primary care training program we are trying to put together; we think that would be a good idea, as well as. having accepted obstetricians and gynecologists as primary care

doctors, we ought to train them better to do that as well.

It is not an unsophisticated training program. It needs that kind of help. So there are some other things we really ought to consider that I am not supposed to say or talk about, because I will get all the cardiologists after me, but I think it is time for us to consider these issues as well.

Senator DURENBERGER. Thank you.

Thank you, Mr. Chairman. The CHAIRMAN. Thank you.

Senator Jeffords?

Senator JEFFORDS. Thank you, Mr. Chairman.

I am going to take a little bit different tack. One of the deep concerns that the people I visit with have about the changing medical profession is the so-called "gatekeeper" and the managed care situation and how efficient and effective and accurate they are going to be-it is going to be some strange doctor they go in to meet who is going to decide whether they are going to get care, or they are going to get two aspirin to take home, or whether they are going to be assigned to a specialist.

And it led me to wonder just what kind of utilization is being made of modern technology to assist in diagnosis, and that led me to talking with a Dr. Weed, whom you may or may not have heard of. I spent an afternoon with him, discussing his knowledge and technology and the utilization of computers to better train people in how to diagnose. And he has apparently convinced the University of Vermont that that ought to be part of their educational sys-

tem.

I was fascinated by the doctor as well as what he could do with his computers and technology, and my question to you is are you considering changing the educational system so that you can better utilize—I noticed in the statements of the two panels, there were two mentions of informational systems, but not really directed to-

ward utilization in diagnosis and things like that.

So I would appreciate your comments, because it seems to me it took the legal profession a long time to get LEGIS, but now they live on it. Fees have not gone down, so I am not sure there is any productivity, but it certainly has dramatically enhanced their ability, and I just wonder what is going on in the medical teaching area.

Dr. NESSON. I would like to comment, because we have put a lot of energy into this, and I think you are right on. It is a phenomenal opportunity, well beyond what is available in many other places.

In our own institution, we have worked very hard to get as much of the medical record on the computer as possible and now are at a new point, having begun in the last half year to have the orders put into the computer. We have all the lab results and the x-rays and the drugs and everything else, and now we have the orders on the computer.

This opportunity allows us to assist a person in making sure they order the right drug, do not order a drug to which the patient is allergic, do not order the wrong dose for a patient who has renal

failure or some other problem whereby the dose should be adjusted. We can even suggest a less expensive drug, and a whole variety of other things. And if they go to repeat a test or do a test that might not be optimal, I think we can also add some education to the per-

son.

Now, we are just instituting this, and we are not forcing people to do it, but we can count, and we can measure what they do and what they do not do. Our opportunity is to look at those things that are useful and make sure they happen and to look at things that are less useful and make sure they do not happen, in an ongoing way. It is one of the few ways to put a control program in to maintain the quality of what we know how to do.

So we now have over a dozen and a half teams of providers working to set some guidelines for how a particular diagnosis should be taken care of, and are hoping to move patients through this kind of a system in a more orderly way, making sure we do all the right things, we and do not miss—do them on a timely basis. We think it will cut our costs significantly and improve the care at the same

time.

I think there is no place where the information overload is far beyond what anybody can remember on their own, and we have a

phenomenal opportunity to use the computer.

Dr. Naughton. I might take a little different tack on that. First, however, I would like to dissuade you from using the term "gate-keeper." I think if the intent of this movement in changing the professionalism of physicians is to succeed, they have to be treated as physicians and trained as physicians. If they are "gatekeepers," that is not going to get the job done. And these primary care physicians, to overcome some of the negatives that Dr. Nesson mentioned, have to be well-trained in science and the practice of medicine, and the specialists are going to have to learn how to integrate with them better and support them. That is a major challenge to educational institutions. So I would hope to dissuade you from using that term, even though I know it is popular in the literature right now.

Second, on communications, there is another side to that story. Obviously, having hospitals do what they are doing is very important and will help cut costs, improve quality, and other things. But if the outreach movement is to succeed and physicians are to feel part of the system, the communications have to be brought to every physician's office. And one of the things we have initiated is a regional pilot in which all of the educational materials that are in our computer education center and all our library materials are now transmitted to fiberoptic cable to seven of the eight teaching

hospitals.

In one hospital, those materials are available on every floor, so you are taking the educational system right to that site. As we move into our rural development, then we will do the same thing, and as we develop our rural sites that we are working on, we will work on that.

So this communications system is really educational, clinical, and

business, to be successful down the road.

Senator JEFFORDS. What about out in the field—are there continuing educational efforts?

Dr. NAUGHTON. There could be no better continuing education vehicle. You have total access to a library.

Senator JEFFORDS. But getting the doctor to use it is the question. I mean, we have terrible problems with—

Dr. NAUGHTON. Well, the new doctors will use it; we old guys may not.

Senator JEFFORDS, OK.

Dr. BONDURANT. Senator, can I just add that we are all working on the continuing education. The Association of American Medical Colleges has an organization of people committed to do exactly this, with representatives I think from every medical school. So that there is throughout the country a broad experience. As a matter of fact, at the annual meetings of the Association of American Medical Colleges, one of the most popular sets of exhibits is the institutions' demonstrations of the kinds of things that Dr. Naughton and Dr. Nesson have just described, and there are scores of them, and people wander around and look at how they are being done in other places.

I think in every institution, this is a popular thing, driven in part by the fact that the young are used to it; this is their way of doing business, and they are at home, and we are being pushed in

part by them.

Our continuing education programs in at least one medical school that I can speak for do explicitly include in many of them, not all of them, but many of them, some exposure of the physicians and, as Dr. Naughton says, we too are building links. Our Governor is very much interested in the information superhighway for the State, and that is a major part of the use of that superhighway. Our AHEC system in North Carolina has long linked medical centers across the State for information transfer; it is a single, big library pool, and we have a large number of physicians who are on line through telephone lines and modems to those information pools.

Senator JEFFORDS. Thank you. I think it would also be very helpful in medical malpractice situations if you had the availability of the records and things that you can provide with that system.

Dr. BONDURANT. That is right.

Dr. NESSON. And people can read them.

Dr. Jeffords. Right. Thank you, Mr. Chairman.

The CHAIRMAN. I would say that we have to do more ourselves here, even in computers, in the Senate. I was the first Senator on INTERNET, and we now have a number of schools in Massachusetts are tied into INTERNET so you get communication via the Email. And particularly in the schools around Massachusetts, they can read the whole statements and not get just parts in the newspapers, if the newspapers even cover these matters. But it has taken a lot even to move us into this area as well, so there is a lot that can be done clearly in the health area that can be enormously important.

One of the new technologies that was funded by the economic conversion was to use a lot of the computer assets in the DOD in terms of the cost evaluations and cost savings. There are some things out there that we can do that can be enormously important

in quality as well as in cost.

I just had one final question, and I will submit some other questions because we have one additional panel to hear.

Dr. Naughton, have you looked over the President's suggestions in terms of the allocations of these positions, and do you generally

think that that is feasible or not?

Dr. NAUGHTON. Well, I think clearly what the Nation needs to do is decide how many residents there are going to be, and clearly, there has to be some broad distribution of them to meet the national goals. But I think the determination by program really has to be done at the local levels, given whatever the cap is that they are working under.

The CHAIRMAN. I would appreciate it—since you have done it if you could give us an analysis of what you think the strengths and the problems are. Could you take a little time and do that?

Dr. Naughton. Certainly.

The CHAIRMAN. That would be very helpful to the committee.

Dr. Nesson, on the funding-and we will have an opportunity, particularly when we have the responses that will come from Phil Lee and the other materials that are being developed by the teaching hospitals—could you tell us, do these cost pressures result from the inadequate support for graduate medical education or from the uncompensated care?

When you are talking to us about what is going to happen in these teaching hospitals, have you thought about that, or programmed that in, or evaluated it?

Dr. NESSON. Well, I think the result is from both. In allocating the dollars that I alluded to earlier, the \$1.9 billion across the institutions, from my institution, that would have been \$140-odd million over the period of time. But when you subtract the coverage for the care, if the access program is in sync, and we would no longer have uncompensated care, it would only be \$100 million.

So a very significant part of the reimbursement need is in relationship to those who are not covered, and so that would relieve it. There obviously is the loss of the financing from the private sector that we now achieve through overcharging them, if you will, which is going to be lost in the managed care environment, where we contract for all our services, and therefore, those numbers have to be included in the calculations.

The CHAIRMAN, OK. Senator Wofford?

Senator Wofford. Thank you, Mr. Chairman. I am so sorry I missed the testimony. I had another obligation hearing 50 witnesses from each of the 50 States on "There is a health care crisis," and they were extraordinary, but I told them that I was missing something else that would have been tremendously valuable, and I will read your testimony with great interest.

Dr. NESSON. Thank you. Dr. NAUGHTON. Thank you.

The CHAIRMAN. We thank you, Harris. We were a little bit late

getting started.

We will submit some questions. This is enormously important, and it has been very, very helpful commentary. We appreciate it very much.

Our final panel includes Eli Ginzberg, director of the Eisenhower Center for the Conservation of Human Resources; Edward O'Neil, executive director for the Pew Health Professions Commission; Dr. Jack Colwill, professor and chairman of the Family and Community Medicine Department, University of Missouri at Columbia School of Medicine; Ann Elderkin is president of the American Academy of Physician Assistants; and Dr. Reed Tuckson is president of the Charles Drew Medical School.

Virginia Trotter-Betts, president of the American Nurses Association, since they are based here in Washington, has been agreeable to come back for our next hearing and testify at that time. We

are grateful to her.

We will hear from Dr. Tuckson first, please.

STATEMENTS OF DR. REED TUCKSON, PRESIDENT, CHARLES DREW UNIVERSITY OF MEDICINE AND SCIENCE, LOS ANGELES, CA, ON BEHALF OF THE ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS, WASHINGTON, DC; ELI GINZBERG, DIRECTOR, EISENHOWER CENTER FOR THE CONSERVATION OF HUMAN RESOURCES, COLUMBIA UNIVERSITY, NEW YORK, NY; DR. JACK M. COLWILL, PROFESSOR AND CHAIR, DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE, UNIVERSITY OF MISSOURI AT COLUMBIA SCHOOL OF MEDICINE, COLUMBIA, MO, ON BEHALF OF COUNCIL ON GRADUATE MEDICAL EDUCATION; ANN L. ELDERKIN, PRESIDENT, AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS, WASHINGTON, DC; AND EDWARD H. O'NEIL, EXECUTIVE DIRECTOR, PEW HEALTH PROFESSIONS COMMISSION, SAN FRANCISCO, CA

Dr. Tuckson. Good morning, Mr. Chairman and members of the committee. My name is Reed Tuckson, president of Charles Drew University of Medicine and Science, and I thank you for this opportunity to present the views of the Association of Minority Health Professions Schools on the training of health professionals within the context of health reform. I have submitted our written testimony for the record and will very briefly summarize my comments by saying that I am proud to represent the 11 historically black health professions schools in our country, schools like Meharry and Howard and Drew, the colleges of pharmacy at Xavier and Texas Southern and Florida A & M, and the veterinary school at Tuskegee in Alabama.

Our schools train to an extraordinary extend the providers who are dedicated and particularly competent to serve the health needs of traditionally underserved communities. Our schools have trained over half of the Nation's black physicians and dentists, over 75 percent of the Nation's black pharmacists and black veterinarians.

Within the context of a health reform that seeks to expand access to health care for all Americans, this becomes particularly important because our graduates consistently choose to work in the underserved inner city and rural sites that are so critical to any notion of universality of health care coverage.

But as important as are the numbers of health professionals that we train and where they practice, how they are trained is also important. Over our many years of teaching and providing care on the front lines of America's health care battle grounds, battle grounds that are in part defined by the disgraceful reality of 75,000 excess premature deaths experienced each year by African Americans, we have learned a great deal, Senator, about how to more cost-effectively and efficiently provide comprehensive and multidisciplinary quality health care to people suffering from overwhelming and interrelated health and socioeconomic challenges.

Our experience has made us passionate about the importance of community-oriented primary care and the necessity of providing preventive, diagnostic and therapeutic health services to whole populations of people from which our individuals patients arise and

must return.

Each day, our faculties and students experience new insights and develop new knowledge about how to provide health care that appropriately controls cost while enhancing quality in populations so

central to the reform effort.

Our experience is a national treasure that ought to be more fully realized, but to do so, we must have the opportunity to survive and to expand our capacities as we enter this exciting new era. We are very enthusiastic about the real possibility at long last for meaningful health reform and urge urgent action because each passing day delivers more premature autopsies in our communities.

In addition to our enthusiasm, we have four concerns that I want to briefly summarize regarding some of the potential implications of health reform that could impede our opportunity to impede our missions. First, academic health science centers require an adequate number and mix of patients with whom to collaborate in teaching and research activities; also, an adequate patient base is

essential to the financial survival of our institutions.

Because we have dedicated ourselves to working in and with poor communities, our institutions are also financially disadvantaged. Universal health insurance that is provided through ever increasingly competitive market systems poses significant threats to us as our traditional patient base suddenly becomes attractive to entrepreneurially-minded, well-financed enterprises.

The competitive playing field ought to be a level and a fair one. Those of us who have made sacrifices for these many years require and deserve capital and technical support that allows our hospitals, clinical facilities and faculty practice plans to compete, to survive,

and to serve the needs of our communities and our Nation.

Second, while we are pleased to observe the growing rhetoric of support for primary care, we are greatly concerned about the availability of financial support for faculty to teach our students in these new community-oriented health care settings, and to do so with the necessary and appropriate coordination between medical student, resident physician, continuing medical education, and the other health care discipline training programs.

Graduate and undergraduate medical education reimbursement must be sufficient in amount and distributed in a manner that facilities that efficient and coordinated education of the physicians of the future and in relationship to their health collaborators. In addition, we are very concerned about how successfully we will be able to compete with other health providers who are not burdened by the added costs of medical education. We are concerned about sustaining our ability to develop new innovations in health care delivery and health services research in community environments, particularly as Federal research budgets are held level or increases limited to traditional bimolecular disciplines.

We urge you to make available specific funding, including the provision that all payers contribute to the cost of medical education, in support of academic centers in general and of inner city and rural community-oriented primary care settings in particular.

Third, our experience also reminds us that our communities suffer from inadequate numbers of all types of health professionals and medical specialists, not just primary care. Despite the relative national oversupply, there are precious few minority specialists of any kind. We would urge you to be committed to be sensitive to our responsibility and requirements for support in the training of the full spectrum of professionals necessary for comprehensive health systems in our communities. National strategies need to be sensitive to the historical inequities that plague the physicians' work force for today.

Finally, sir, I would say that the other area that is important is that we enjoy and share the goal of the AAMC to reach 3,000 minority physicians in training by the year 2000, and we are glad to see that in the President's health reform package. I would say to you, though, we need very specific support for the pipeline of programs that develops our children from the earliest Head Start programs all the way through in a continuum of high school programs all the way through to college, on weekends, in evenings, and in the summertime. We have pioneered that work and would urge you to support that and make funding available.

Our recommendations are very much contained also within the report on under-represented minorities in the Council of Graduate Medical Education Report, and we would urge you to look at those

as you go forward with your legislative initiatives.

Thank you for the opportunity to testify today.

The CHAIRMAN. Thank you very much, Dr. Tuckson. You covered more than the President did last night, in one-quarter of the time, an ambitious program.

[The prepared statement of Dr. Tuckson may be found in the ap-

pendix.

The CHAIRMAN. I would ask the witnesses if they could to summarize their statements. Senator Wofford and I both want each of you to have the opportunity, and we are getting into a tight time framework.

Dr. Ginzberg?

Mr. GINZBERG. This is the 50th year that I have been coming to Congress to testify on these and related matters, so I am not going to

The CHAIRMAN. We never get tired of hearing from you. We are

going to do something this time.

Mr. GINZBERG. I guess I will take advantage of that perspective. The first thing I want to point out is that while I surely agree that you ought to move to reduce the training of subspecialists and increase the number of generalists, there is a reality point here that is very important, and that is we just finished a study of the four largest metros of the United States—New York, Chicago, Los

Angeles and Houston—and the variation of doctors in the inner cities in private practice, relative to the people who need care versus the suburbs are 50-fold. We have about one private physician to 300 persons in the suburbs, and you have about one private physician to 15,000 in the inner city. So that while you can keep on changing how doctors are trained, unless you can pay a lot of attention to how doctors are attracted to practice in different parts of the country, how they are paid, the change in the composition of the training is not going to do the job. That is the first big point I want to make.

Second, I think the Congress has to go back and remember that it passed the National Health Services Corps in 1970 in order to accomplish a better job of putting the personnel where the people needed them, and it has not been a happy story. So I think you had better go back and think about why it has not been happy; it

has not been funded properly.

You do not want to use this occasion for a major reform of the health care system and not take advantage of some of these past experiences. The Congress passed a law in 1976 that said that the medical schools that did not produce 50 percent generalists would no longer be entitled to funding under the Health Personnel Act, and then they had to rescind it.

So this is all a reminder that a lot of stuff that has happened in this field of trying to get things balanced off has not worked so

well.

Another point I want to make is that I am not quite so interested in the ratios. There is a Mendenhall study from Southern California in 1979 which indicated that specialists provide about 20 percent primary care anyhow. They just do it. They have chronic cases. If you happen to be an older person, and you have problems with diabetes, your basic care can be given to you by a diabetic specialist just as well as by a generalist. So I think you have to watch that.

As I look at primary care around the country, I am impressed with the fact that we have got three or four different ways of providing it now. Palo Alto and the Mayo Clinic use subspecialists, with mid-level assistants like nurse practitioners, and they work it out that way. That is one. In New York City, we use residents pursuing specialized training, because they are the only people available to treat the poor.

There are different ways. In the rural areas where there are federally-subsidized clinics, the Congress has said a long time ago that the nurse practitioners can run them and be reimbursed. So I do not think we ought to get overly impressed with very simplistic

ways of handling this.

I want to make two suggestions in specific to the committee. One is that I think if the Federal Government is serious about trying to avoid the overtraining of specialists, they should decide that the Federal Government will not go beyond first certification; that is, 3 years of subsidy for GME, or 5 years if you go for general surgery, and that is it.

The second suggestion that I would have is that Robert Ebert, the former dean of the Harvard Medical School, and I recommended years ago, in 1988, that you could save 2 years in the

training of a physician out of the 7 years if you went back to the old system. That is, you permit students at the end of their junior year in college, the good students, to go into medical school, and then Bob Ebert and I suggested that you combine the 2 last years of clinical training and the undergraduate, and the 3 years for certification and put that into a 4-year program. That is a 28 percent saving in the preparation of a physician if you did that.

So I am really suggesting that this is a time when we should not get stuck, or overstuck, on thinking that because we keep on repeating the words, "primary care," that by just having more primary care physicians, that is the only way the Congress can move, or that is the only way that makes sense. I would like to have this

a little bit looser and more open.

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Ginzberg may be found in the appendix.]

The CHAIRMAN. Dr. Colwill?

Dr. Colwill. Thank you, Senator.

I am Jack Colwill. I chair the Department of Family and Community Medicine at the University of Missouri. I am here as a rep-

resentative of the Council on Graduate Medical Education.

With this testimony, I am submitting for the record the Fourth Report of the Council on Graduate Medical Education. That report contains a legislative plan which is really addressing the issues we have been talking about here this morning. Its goals are consistent with proposals introduced by the President and by members of this committee.

The Council believes strongly that successful reform must contain effective strategies to train more generalists and fewer specialists. It must also increase the number of minority physicians, and it must approach the problem of geographic distribution. I shall focus my comments on those aspects that are dealing with grad-

uate medical education.

I believe all of us know that as we progressively move to managed care, the demand for generalist physicians is going to increase, and that of specialists is going to fall. The Bureau of Health Professions in one of its models projects a shortage of 35,000 primary physicians in the year 2000. At the same time, it will have a surplus of 115,000 specialist physicians. This assumes a major movement toward managed care.

Market forces seem unlikely to address these problems in the short term. Consequently, COGME feels that the failure to train adequate numbers of generalists will hinder efforts to initiate

health care reform and to develop effective systems of care.

COGME believes that we can no longer fund unlimited numbers of residency positions with Federal dollars. It recommends that public funds be utilized to obtain the necessary number and specialty mix of physicians. Consequently, the Fourth Report provides recommendations which assure that 50 percent of graduates enter practice as generalists; it limits funding to the number of U.S. graduates plus 10 percent; it allocates the reduced number of GME positions to consortia, and it provides that funding be provided by all third party payers.

The centerpiece of this proposal is the development of private sector consortia. These consortia would be composed of one or more medical schools, teaching hospitals, other institutions which train physicians, and representatives of the public. The Department of Health and Human Services would allocate a reduced number of residency positions to each consortium, utilizing criteria developed by the National Physician Work Force commission.

Funding of each consortium would be conditioned on an increase in generalist positions and a reduction of specialty positions, so that half of those who completed training would enter practice as

generalists.

Decisions on allocation of specialty positions would be made together, by members of the consortium, based upon local, State, and regional needs as well as the quality of individual programs in the

consortium.

With implementation of these recommendations, this Nation would produce 25 percent fewer physicians, of whom half would be generalists. The reduction in residency positions has potential to create difficulty for many of the Nation's teaching hospitals. Resident physicians help meet service needs of teaching hospitals. COGME believes that the medical education payments saved by the overall reduction in residency positions should be redirected to assist those hospitals most affected. The proposed changes would be phased in over several years. Some of the dollars should also be utilized to assist in the development of an increased capacity to train generalists.

If Congress enacts COGME's recommendations, our Nation will produce a physician work force that is closely matched to tomor-

row's needs.

I do want to thank you for this opportunity.

The CHAIRMAN. Thank you.

[The prepared statement of Dr. Colwill may be found in the appendix.]

The CHAIRMAN. We will hear next from Ann Elderkin.

Ms. ELDERKIN. Mr. Chairman and members of the committee, thank you very much for this opportunity to testify on behalf of the more than 27,000 physician assistants in the United States. The PA profession applauds President Clinton for his far-reaching plan to reform our Nation's health care delivery system. The President's proposal is the most comprehensive set of recommendations developed to date. The President recognizes, and many members of this committee today have pointed out, that we must 1) expand our vision of the health care delivery system, 2) enhance the services provided, and 3) increase the number of professionals that will be needed if universal coverage is to become a reality.

First and foremost, the President's bill reflects an important

First and foremost, the President's bill reflects an important change in the way we think about the services that are of value to patients. Currently, third party payers reimburse practices either for physician services or medical services. The Clinton plan provides coverage for health professional services, which includes physician services provided by health providers who are not physi-

cians

Moreover, it retains the concept of medically necessary services, and it preserves the traditional authority of the State to determine qualified providers, as Dr. Lee indicated in response to a question

from Senator Pell earlier.

Over the past 25 years, most States, including our own home State of Massachusetts, Mr. Chairman, have improved the laws that govern the practice of PAs and other health professionals. Unfortunately, some States, including those with the most severely underserved populations, continue to place unnecessary limits on PA practice.

This brings me to my second point—enhancing services. The Clinton plan seeks to work with the States to remove inappropriate obstacles to the full utilization of health care providers. We support the President's efforts in this regard and are hopeful that within a few years, PAs will have prescriptive authority in all 50 States, not just 35, and that PAs would have scope of practice and physician supervision requirements that are reasonable and appropriate.

Third, we believe the President's plan takes some important first steps toward ensuring an adequate supply of health care providers to meet the expected increase in demand. Much attention has focused on efforts to change the mix of physicians so that at least 55 percent are choosing a primary care specialty by 1998. Relatively little attention has been paid to the administration's call for signifi-

cantly more PAs and nurse practitioners.

The Clinton plan authorizes an additional \$400 million for training more primary care providers. PAs are seen as part of the primary care team and would receive a significant increase in Federal support, assuming the money were appropriated. Here, Mr. Chairman, is where we have concerns about the funding provisions of the Clinton legislation. As Senator Harkin, chairman of the Labor-HHS Appropriations Subcommittee, can tell you, and as Senator Wellstone alluded to in his questions to Dr. Lee, the new authorization may be meaningless in light of the domestic spending caps in the budget.

So that while we welcome the administration's desire to invest more in the education of primary care providers, the \$400 million might be an illusion, and we support those efforts to increase it

and to dedicate the funding.

We are quite enthusiastic about many of the provisions in the Clinton legislation, but we do believe there are three specific ways in which the bill can be improved. One, increased Federal support for PA educational programs is needed in order to produce more PAs. We would like to see a funding source dedicated to the education of PAs; it does not exist currently. Either a portion of the new graduate medical education funds that will be created, or an additional tap on alliances for this purpose.

The results would be dramatic. The supply of PAs would increase relatively quickly to help meet the enormous demand that is already taking place. Hospitals could fill service needs created by cutbacks in residency slots. HMOs, group practices, and others would find PAs available to deliver high-quality, cost-effective

health care.

No. 2, to help PA students with the cost of their education, we recommend modification of the National Health Service Corps language. The administration has recommended awarding scholarships and loans with the goal of making nurses 20 percent of all

individuals in the corps. We recognize the need to increase the number of nurse practitioners and nurse midwives, but the practical effect of this language will be the elimination of scholarships

We propose instead that the current 10 percent set-aside for PAs, nurse practitioners, and nurse midwives be increased to 20 percent, and that the set-aside include both scholarships and loans. This approach will result in more nurses coming into the corps, without

disenfranchising PAs.

Third, we are concerned that despite all the efforts to promote a team approach to health care by improving payment and eliminating obstacles to practice, the Clinton plan perpetuates a fragmented approach to work force planning. Rather than establish a national commission on graduate medical education, a national commission on graduate nurse education, and a national institute on health care work force development, why not establish one national commission that would look at work force issues from a global perspective?

In conclusion, the PA profession welcomes the Clinton health care reform proposal not only for what it will do to provide universal coverage of cost-effective, quality health care, but also because it represents a new way of thinking about health care delivery.

Thank you.

Senator Wellstone [presiding]. Thank you.

[The prepared statement of Ms. Elderkin may be found in the ap-

Senator WELLSTONE. Dr. O'Neil?

Mr. O'NEIL. Thank you, Senator Wellstone and members of the

I am Dr. Edward O'Neil, executive director of the Pew Commission on Health Professions and an associate professor of family and community medicine at the University of California at San Francisco.

The commission is chaired by a former Governor of Colorado Richard Lamb and is a private body funded by the Pew Charitable Trust, in charge of examining how health professional education and work force reform can support the cause of broad general health care reform.

For the past 5 years, we have looked at how the 10.5 million health care workers and the \$30 billion that we spend educating

health professionals can more effectively be spent.

Because the day has been long, we have submitted in the testimony the recommendations past just yesterday by the Health Professions Commission for your consideration, but let me make four points that I think, unless this committee attaches attention to these issues, the legislation that you pass simply will not be effective.

The first thing is that a national health professions development board, addressing all health professions, needs to be a part of this legislation. Let us not kind ourselves what this piece of the legislation is about. It is reducing the size of certain parts of the professional manpower. And that will only come about with a centralized Federal authority. It will not come about any more than closing military bases came about without creating a specially congressionally-chartered military base closing commission. Without it, it simply will not happen. There is no market force strong enough to shrink the size of medical subspecialty residencies fast enough to

make a significant impact on the public.

That said, that board needs to articulate its policies in a set of national goals, with a distinct set of local needs. I am pleased to say that the center that I represent from the University of California is currently working on a detailed proposal on exactly how that articulation can come about, but it has to balance the market as well as the regulatory needs. A national health professions develop-

ment board has to be a piece of your legislation.

The second element that you have to include for your legislation to be successful is an all-payer pool. We have to break the hold that patient care revenues have on all clinical disciplines and clinical training programs. A simple, direct means for funding health professions education does not mean more money; it means to clean up the myriad of legislation, laws, pass-throughs, paybacks, switchovers that currently fund these programs. We need that simple and direct mechanism because we need to be able to purchase the kind of health professionals that we need as a Nation, at the Federal level and at the individual State level.

The third thing that we need is a balanced production of generalist and specialist physicians by the medical education community. We agree from the commission's perspective that a 55-45 generalist to specialist ratio by 2002 is absolutely necessary. Regardless of what any studies say about the needs or how we come up with 55-45 or 50-50, a witness earlier today said it would be okay for us to continue to educate subspecialist physicians because we could always retrain them. Every time we do that, we make a \$750,000 mistake, and we wreck 7 years of someone's life. We need to be careful before we make those decisions.

Finally, we need to expand training support for other primary care providers, particularly nurse practitioners, physician assistants, and community health workers, as well as the incumbent policies to expand practice for those health care workers and the

contributions they can make to primary care.

Thank you for your time.

Senator Wellstone. Thank you very much, Dr. O'Neil. That was very strong testimony. I appreciate all your points, especially your first one.

[The prepared statement of Mr. O'Neil may be found in the ap-

pendix.

Senator WELLSTONE. I am at a little bit of a disadvantage, but it is not going to stop me from, if you have just a little more time, trying to raise some questions with you. The disadvantage is that I thought I could get back sooner, so I do not have the text of your testimony. I feel like a student who did not study for the exam—although I will read it.

The second disadvantage is that I left my glasses in the office, so that when I tried to read it, I could not read it. Now, if I have

you shedding tears for me, I can go forward.

One question I wanted to ask, and I do not know if you covered this earlier or not—one question that is kind of etched in my mind is this question of the kind of training of caregivers, broadly defined, and how to begin to dramatically change the mix of specialists versus those who are in primary care in one way or another. But then there is a second issue, which is how to get those caregivers out into the communities, and especially in underserved communities. And then—and I am not going to make this into a single-payer forum; I am a strong single-payer proponent—then we have the alliances, and we have accountable health care networks that compete against one another to keep costs down. That is part of the basis of the competition. That is the market part. But then we know that certain people are more expensive to actually provide care to. So I am getting nervous about these incentives, in other words, who is marketed to and who is not, and where they locate and where they do not, and whose phone calls they return. So then I begin to worry about where the poor fit in, and I begin to worry about where people who are struggling with mental illness or substance abuse fit in, or where older people fit in.

So I wanted to get some sense from you all as to what you think are the most important steps that we can take to make sure that what we call primary care is in fact delivered to people in communities in our country, including those people who have been the least well-served by the way we now finance and deliver health

care.

It is a broad question, but I hope you will consider it to be a rel-

evant one, and if it is completely repetitive, I apologize.

Mr. GINZBERG. No, I do not think it is out of context at all. You did not hear my testimony, which was that in the recent research that we have done, the disproportion between the number of people available to treat the poor in the inner cities of the United States—we studied four major metropolises in the United States—had one private practitioner available for each 15,000 population, and in the suburbs it was one for 300.

So that the question you are asking is no matter what you do on insurance and so on, how do you get physicians to go where they have not been going in the past, to take care of the people who

have been ignored.

Senator Wellstone. Physicians and others.

Mr. GINZBERG. Oh, yes. I use that now colloquially; definitely with others.

Senator WELLSTONE. Ann gave me a dirty look, so I quickly modified that.

Mr. GINZBERG. Yes, I know. That is just a shorthand.

I would say you really have to look very carefully again at the question of the community clinics, federally supported, and maybe you could make a deal with the States so that you would give some money to the States so they could begin to do some matching. Unless you do that, unless you have physical facilities close to where the poor go, they are going to continue to go to the emergency rooms and get lined up. There is just no way.

I think the other thing you have to worry about, and I also put it in my initial testimony, is you have to take a look at the National Health Service Corps. You have to beef that up. You have to make it worthwhile for physicians who would not normally be attracted to treat the poor in the poor and rural areas to a) have a place to practice medicine decently in a group setting, with defi-

nitely other people to help them—that is very important because that is the way you keep your costs down—and b) you have to worry about the facilities, because if you do not worry about the facilities, you will never get them there.

Dr. COLWILL. I would like to take a shot at that, if I could, also,

rather simplistically.

Senator Wellstone. Sure, absolutely.

Dr. Colwill. I think you need to train the right docs for that area; you need to have financial access for the patients; and then, in those areas where you still do not have the problem, you need to have the National Health Service Corps and the types of things that Eli was bringing out that will help get the job done in the most difficult areas.

Dr. Tuckson. Let me also mention, again representing the Association of Minority Health Professions Schools, that we have a very strong track record and experience that tell us that as we enroll students from rural communities and inner city communities, and physicians of color and other health professionals of color, that they have a much stronger tendency to return to those environments and to do that work. So a large part of this is making sure that those schools that are training such individuals have an oppor-

tunity to survive.

Second, I think it is very important to spend a lot of energy on how we train them. The proposals for how we fund and organize community-oriented primary care is very important. Much of the testimony we heard earlier today that talks about who gets the money for graduate and indirect and direct education and so forth, while very important, not question, still misses a larger question which is how do we coordinate that money such that the resident is freed and able to leave at appropriate times the tertiary care hospital and work in the community environment, and how do we coordinate that resident's training in the community with the medical student's training from another source of money which, by the way, is not well-identified. And then, how do you then create the funding stream and the incentives to support the physician and the physician assistant, the nurse practitioner, the nutritionist, to all work together in a training environment such that they are comfortable as well as competent to be able to do that work.

Third, there needs to be a level playing field out there for those who have been working in those communities doing that work, who have a very real chance of getting run over by very well-capitalized

business entities.

And finally, I would just say that I know you are particularly sensitive to the need for providing resources for what are called enabling services such that as you are trying to do primary care in these environments, you are not out there alone, building sand castles on the edge of the tide.

Senator Wellstone, Dr. O'Neil?

Mr. O'NEIL. Senator, as supportive as the commission is of the Health Security Act—we believe it is a good health care plan for people who subscribe to and read "Consumer Reports"—the populations that you describe do not seek good care that way, do not subscribe and seek information that way.

We created over the past 2 decades or longer a public health infrastructure, maternal and child health, reproductive services, Title X, public hospitals, that are in jeopardy—in fact, they are probably more in jeopardy than the academic health centers that we heard from earlier. And the support from those institutions is likely to erode as a standard benefit is allocated to those populations. Without the sensitivity to allocate that resource in a useful way, we may put those populations—right at a time when we think a universal benefit gives them better access, we may put them more at risk.

Senator WELLSTONE. Well, that is one of the really bitter ironies that I am afraid of. That is exactly what I am really worried about.

Ann?

Ms. ELDERKIN. Senator, all the ingredients that go into recruiting physicians to underserved areas are true for the physician assistant profession as well. We have a very good track record, however, and we are seeing an increase in PAs returning to underserved areas, because in particular, we use recruitment and we use training in the underserved areas in primary care.

A wonderful example is a new program in Sitka, AK, which is affiliated with the University of Washington, which is a satellite program which recruits native Alaskans who have health care experience to go on and get training to become a PA and then will

stay in the community to do that.

One of the things that we find helps physicians in staying in underserved areas is having the kind of team support that this panel has been talking about, medical institution supports, having PAs there as well to help that so that they do not burn out by being the sole provider in a community, being on-call 7 nights a week, that they have some relief, and they have some of that support.

The other ingredient that is important, though, when you are talking about nonphysician providers is to remove some of those obstacles that are at the State regulatory level. A very clear example

is prescriptive privilege authority.

I just happen to have with me a map of the United States which shows in the black States, those that have prescriptive legislation at the State level, and in the white States, the Southern, the Midwestern, and particularly the Southern areas are some of the most underserved rural States that you could imagine, and yet they do not have legislation which would allow PAs to be of great benefit to enhance the practices of physicians and community health centers and so on. It is public policy that does not make sense with the kind of need that we are seeing now. So it is something to be taken into consideration.

Senator WELLSTONE. Yes, it seems to me that—and I am not going to hold you much longer—but it does seem to me that as opposed to just injecting dollars into the health care system as it is right now, I think we should actually use those dollars to leverage

change of the kind you are talking about.

The other thing that occurs to me—and this goes to your point, Dr. O'Neil, and I think also to what Dr. Tuckson said and to what all of you said—is I think that if the President's plan is the starting point, we really do need to make sure that—and I think Dr. Lee is well aware of this and a very strong supporter—that this in-

frastructure of delivery which we have had, which has really worked well, like community health care clinics and so on—that there be a clear stable source of funding that remains a solid part

of how we finance and deliver health care.

Otherwise, I think you are right. The irony of it is it is now in theory universal coverage, but it just is not going to work that way. And universal coverage can mean a lot of different things to a lot of different people, but if it also means humane and dignified care, culturally sensitive care, empowering people and neighborhoods—there are a lot of areas that I can think of where I have worked over the years where people are not going to be reading these outcomes-based research reports every year. It has got to be much different.

Dr. Tuckson. Senator, I just want to say, as we connect the point that Ed made, that the academic health centers need to be very much connected to that public health infrastructure.

Senator WELLSTONE. Yes, and they are not; right?

Dr. TUCKSON. They are not, and we are trying to get that.

Senator WELLSTONE. Or in general they are not.

Dr. Tuckson. When I was health commissioner in this city, it drove me nuts that as a health department out there by ourselves, we did not have the academic health sciences centers with us in the fight. They were completely distinct from us, no connection at all

Now we are starting to see this need to connect and bring together. So I think the point is that the two agendas really are beginning to merge, and what we have to be creative about is how to really push that forward.

Senator WELLSTONE. I agree, and I think we have got the possi-

bility of doing that, I really do.

Senator Wellstone. Well, I would like to thank you, and my only apology is for missing part of your testimony, and I hope to be able to talk to you all more.

Thanks a lot.

[The appendix follows.]

# APPENDIX

### PREPARED STATEMENT OF DR. PHILIP R. LEE

Mr. Chairman and members of the Committee, I welcome this opportunity to discuss two important components of the President's Health Security Act—the health

care workforce and the academic health center provisions.

However, before I turn to the specific provisions, it is important to take a moment to put the public health initiative in perspective. In recent years, as the private health insurance system failed more and more working Americans, State, and local public health agencies became increasingly involved in providing personal medical

care and mental health services to the poor and uninsured.

In an environment of limited resources, this shift in public health spending to-ward personal medical care was at the expense of public health programs designed to keep communities healthy. This steady erosion of funds led the Institute of Medicine in 1989 to declare the public health system to be "in disarray" and a "threat to the health of the public." The American Public Health Association, in its recent report "Public Health in Reformed Health Care System: A Vision for the Future", reiterated these problems. We have confirmed these reports in our own analyses during the past year.

We now have an historic opportunity to improve the health of the American people. Under the Health Security Act, we will do far more than just treat people when they are sick. We will achieve the fundamental goals of our nation's health pro-

motion and disease prevention agenda:

Increase the span of healthy life for Americans and reduce health disparities among Americans.

If we reform the personal care system as the President has proposed, the public health system will no longer need to provide covered personal health care services to indigent and uninsured populations. Instead, public health agencies can turn their resources and expertise to their original role of protecting the health of communities and removing barriers to medical care.

I would like to turn now to the provisions of the Health Security Act relating to the health care workforce and academic health centers, issues that have been a

major concern of the Members of this Committee for many years.

Workforce and academic health center policies are critical to achieving the impor-

tant health care reform goals of security, savings, and quality.

Security and the Workforce. An adequate supply of appropriate providers is essential to the principle of security—of assuring people they will have access to medically necessary and appropriate care when they need it.

Our workforce today is maldistributed by both geographic area and by specialty. Many urban and rural areas have too few primary care physicians and some have

no providers at all except the nearest emergency room.

Despite these shortages, the skills of nurse practitioners, nurse midwives and other types of non-physician primary care providers are under-utilized.

The under-representation of minorities among the health professions is a severe barrier to care for many underserved populations. Increasing diversity in the health professions is essential to assure availability of culturally sensitive care as well as to provide a genuine equality of opportunity for minorities to pursue health careers.

Savings and the Workforce. The problem today is that we have too many physicians practicing in specialties and subspecialties other than primary care. Graduate medical education (GME) has been driven by economic incentives in the payment system, rather than by policies directed to meeting the health care needs of the American people. The long-term absence of national policies regarding physician training has led to a specialty-dominated system which generates unnecessary health care spending.

The current imbalance has been encouraged by federal policies, and it will not be reversed without explicit changes in incentives. Beginning in 1963, the Federal government initiated policies to deal with what was widely perceived to be a physician shortage. At first, grants and loans were provided to expand facilities. Then, direct Federal support was provided for medical education. These policies succeeded in in-

creasing the number of physicians.

Early in this period, there were roughly 300,000 active physicians or about 150 per hundred thousand population. Currently, there are almost 600,000 active physicians in practice and we have a ratio of 230 per hundred thousand population. At current training levels, by the year 2020, there will be 875,000 active physicians, or a ratio of over 300 physicians per hundred thousand population.

Despite the rapid growth in physician supply, we continue to add to our pool of physicians many graduates of international medical schools who enter residency training in the U.S. One-fifth of all practitioners are now international medical graduates and approximately one-fourth of all first year residents are graduates of schools abroad. This growth has been supported by Federal policies initiated in the 1960's and 1970's to grant physicians preferred immigration status. The creation of 1960's and 1970's to grant physicians preferred immigration status. The creation of large numbers of residency positions in hospitals providing care for low income pop-

ulations has provided the employment base to absorb these graduates.

In addition to excess numbers, physicians are badly distributed by specialty. More than two-thirds of physicians in the United States are specialists, and under current policy this specialty mix will continue into the next century. Today, over 65 percent of new physicians are trained in the non-primary care specialties and subspecialties.

Physician overspecialization have severe cost and quality implications. The average cost of an additional physician in practice has been estimated at between \$500,000 and \$1.0 million a year—three-quarters of which is related to physiciangenerated expenses. Because specialists generate far more tests and procedures than primary care physicians, an over-supply of non-primary care specialists drives up costs without improving patient outcomes. It would be very difficult to create payment and utilization controls to overcome practice patterns instilled through many years of training. We clearly need to slow long-term growth.

Quality and Academic Health Centers. The high quality of health care in the United States is directly associated with the special role and mission of our nation's

academic health centers (AHCs).

AHCs and their affiliated teaching hospitals educate most of the health care providers and biomedical researchers trained the U.S. They foster the rigorous pursuit of biomedical and health systems research which have made the U.S. the leader in technological and therapeutic discovery.

Academic-centers provide sophisticated and scientifically advanced care for a wide range of patients and maintain critical services such as transplant centers, burn units, genetic laboratories, and other unique services not available in community

hospitals.

Maintaining these centers of excellence entails special costs that are now paid through direct payments and indirectly through reimbursement for services. As health care reform creates changes in reimbursement systems, we must assure that it does not diminish access to the specialized care offered by AHCs, or slow new advances in medicine, or undermine the training of physicians and other health profes-

# PROPOSED POLICIES FOR WORKFORCE AND ACADEMIC HEALTH CENTERS

Title III, Subtitles A and B of the President's Health Security Act will provide strong new national policies to improve the workforce and support the special misstions of academic health centers. The instruments to accomplish these goals are three new funding pools that will subsidize physician and nurse training and support for academic medical centers. The training subsidies will produce a workforce distribution better calibrated to service needs, and to the provision of cost-effective The subsidies to academic health centers will protect their core capacity for excellence in training, research, and the provision of highly specialized services.

The first would finance the direct costs of graduate physicians training. The second would fund the training of nurse practitioners and graduate level nurses. The third pool would support the unique mission of academic health centers in training health professionals, conducting research, and providing specialized services and caring for patients with complex illnesses.

These pools are funded from projected Medicare payments for graduate medical education and indirect medical education and additional payments from private insurance premiums and other funds. The three pools would together total almost \$10

billion when fully implemented in 1999.

This approach is fairer than the current system because it spreads training costs for the next generation of health professionals, and support of research and special service activities of academic centers across all health care plans. They also help guarantee that academic centers can compete with other providers for patients and, thus, continue to play their important role in our health care system.

Health workforce reform policies

In addition to assuring adequate support for graduate physician training, the national graduate medical education pool provides a mechanism for making decisions with respect to the numbers and types of new physicians that we will need in the future. The goal is to achieve a better fit between the health care needs of the American ican people and the supply and distribution of providers.

Projecting workforce requirements by type of practice and geographic area in a dynamic society such as ours must be done with care, excellent information, and close consultation with all affected parties. The President's plan proposes that decisions regarding the number and specialty mix of new physicians be made by a National Council on Graduate Medical Education, with members of this council representing all interests affected-consumers, educators, practitioners, the alliances and the plans, and others.

Through a deliberative process which considers the recommendations of the professional community, the Council would establish national goals for the number and

type of new physicians to be trained, beginning with academic year 1998-99.

Once national goals are set, the Council would allocate available positions among individual training programs. Funds from the graduate medical education pool would only be paid to institutions for approved training positions. The allocation of positions will increase the ratio of generalists to specialists. The goal would be for 55 percent of residents entering residency training in academic year 1998 to subsequently enter practice in family medicine, general internal medicine, general pediatrics, or obstetrics and gynecology.

In setting targets and making allocations, the Council would consider the extent of need for additional practitioners in each specialty, the historical training patterns, the extent to which programs draw trainees from diverse populations, and the

recommendations of physician and consumer organizations.

The program also has the goal of gradually reducing the number of first year residency training positions from the current level of 135 percent of the number of graduates from U.S. allopathic and osteopathic medical schools, to a number more closely approximating the number of U.S. graduates. Last year, for example there were about 24,000 first year residents in training and about 17,300 graduates from U.S. allopathic and osteopathic medical schools. The plan does not set an exact numerical

target for reductions, but leaves flexibility to determine percentage reductions.

The funds from the graduate medical education pool will be paid to training programs which may be sponsored by academic health centers, medical schools, clinical departments, hospitals, clinics, HMOs, or multispecialty groups. The broad range of eligible organizations, will encourage increased training in ambulatory settings.

While specialty changes and the downsizing of the resident workforce would be phased-in over the next decade, hospitals with large specialty training programs will be affected early and will need to adapt. Although the primary goal of residency training is education, residents also provide considerable patient care at a low cost. To facilitate adjustments in hospitals which end up training fewer residents overall, the Act provides transition payments for a four year period.

#### Graduate nurse education

A second \$200 million national pool would be established to support graduate nurse training, and is configured in a manner similar to the physician training program. The pool will support advanced nurse education programs, including nurse practitioners, nurse midwives, nurse anesthetists, and clinical nurse specialists requiring advanced training.

A National Council would establish targets for the specialty mix of nurses and allocate positions to individual training programs. Nurses trained would meet immediate needs for more primary care providers, and provide a pool of nurse specialists able to provide much of the care previously provided by hospital residents, as the

resident pool is downsized.

#### Related workforce programs

An additional \$400 million per year is authorized for other workforce programs in the Public Health Service. To expand support for existing primary care authorities which assist development of generalist residency training programs, training in rural and underserved areas, and other related programs which foster an interdisciplinary, primary care workforce.

In addition, funds would expand opportunities for underrepresented minorities, so

we can move more aggressively to the goal of diversity in the workforce.

Finally, there would be additional support for nursing at the undergraduate level, for special training in school health, for development of new training programs for nurse practitioners and physician assistants.

#### Academic health center policies

AHCs and their affiliated teaching hospitals are higher-cost providers than community hospitals. Private insurers now pay roughly 25 percent more for treatment in academic health centers than they do for similar services in community hospitals.

If AHCs and teaching hospitals are to continue to play their critical role under the more competitive health care system envisioned by the President's Health Secu-

rity Act plan, two steps are necessary.

First, there will need to be special financial support to offset costs in AHCs which are inherently higher, a legitimate product of training physicians and other health professionals, conducting clinical trials, research and technology development, and building and maintaining the capacity to provide specialized care.

Second, even with a national pool to subsidize the special missions of academic centers, AHCs will have to become more price competitive relative to other patient

care institutions by revamping their organization and operations and so improving their efficiency and productivity.

The Health Security Act, as previously discussed, establishes two pools to support direct graduate medical education and graduate nurse training. These two pools, to talling \$6.0 billion in 1999, are very important to the future of academic centers and teaching hospitals.

The third pool, for academic health centers and teaching hospitals is funded at \$3.7 billion in 1999. This pool is especially important as it provides support for the less well specified but never the less real additional costs of these institutions.

Funds from this pool will be allocated to academic health centers and teaching hospitals based on a formula which takes into account an institution's intern and

resident-to-bed ration and total (all-payer) inpatient and outpatient revenues.

This approach changes the current Medicare indirect medical education (IME) payment formula, by taking into account the impact of universal health insurance coverage. As universal health insurance becomes a reality, Medicare will contribute to the AHC pool at a rate to reflect the added costs of residency programs, based on the intern/resident-to-bed ratio. Moreover, MCR DSH payments will be retargetted to vulnerable populations.

In addition to receiving explicit payments for non-patient care services, AHCs will also continue to treat patients with rare and complex conditions that need special-

To ensure that patients are referred to AHCs for specialty services that are best provided in such centers, alliances and health plans will be required to make specific arrangements with AHCs.

Contracts. In order to guarantee that patients will have access to the specialized services offered by AHC hospitals, health plans will be required to contract with an AHC for referral and treatment of patients with rare diseases or unusually severe conditions, and for providing other specialized health care.

Clinical trials. Routine care during investigational treatment is a covered service. Alliances will provide consumers information on availability of clinical trials to ensure appropriate access.

Quality assurance. Alliances and the National Health Board will provide quality assurance and appeal mechanisms to assure that health plans are appropriately referring members to special hospitals.

### CONCLUSION

I thank members of the Committee for this opportunity to discuss these important features of the President's Health Security Act. I will be pleased to answer any questions you may have now.

# PREPARED STATEMENT OF H. RICHARD NESSON

Mr. Chairman and Members of the Committee, thank you for inviting me to testify today on how the Health Professions Workforce and Academic Health Center provisions in the Health Security Act would affect Massachusetts teaching hospitals.

I am H. Richard Nesson, President of Brigham and Women's Hospital in Boston. am here today on behalf of a Coalition of Massachusetts teaching hospitals, and will am here today on benail of a Coalition of Massachusetts teaching hospitals, and will providing impact analysis is based on data from the following institutions: Bay State Health Systems, Beth Israel Hospital, Boston University Medical Center, Brigham & Women's Hospital, Carney Hospital, Children's Hospital, Faulkner Hospital, Massachusetts Eye & Ear Infirmary, Massachusetts General Hospital, New England Deaconess Hospital, New England Medical Center Hospital, St. Elizabeth's Medical Center of Boston, and University of Massachusetts Medical Center.

Each of these hospitals is a major employer, health care provider, physician training center, and research institution. They employ 40,180 full-time equivalent employees in Boston, Worcester, and Springfield. In 1993, they provided 2.9 million outpatient clinic visits, 600,000 emergency room visits, and 263,000 admissions.

Their patient service revenue in 1993 was \$3.3 billion; total payroll is \$1.8 billion. In 1993, they trained 3,027 residents and were awarded \$297 million in NIH re-

search grants (43 percent of the total received by all of the nation's independent hospitals.)

It is exciting to be here today, at the start of a Congressional session in which the prospect of comprehensive health care reform has never been more real.

We thank the Administration for taking the lead in moving health care reform legislation, and thank Senator Kennedy for having championed the cause of health care reform so many years. His leadership has brought us to this critical juncture.

We believe our mission can only be enhanced by the passage of comprehensive health care reform legislation. Teaching hospitals and academic medical centers in Massachusetts, and around the country, serve a three-part mission. We provide patient care, train future health professionals, and perform biomedical research. We intend to continue our role as leaders in shaping health care delivery and policy for the nation and plan to meet the challenges posed by health care reform head-on.

There is too much at stake to do otherwise.

have been asked to comment today on the provisions of the Health Security Act addressing Graduate Medical Education, the Health Professions Workforce and Academic Health Center provisions. Of course, there are several bills before the Congress designed to revise the funding and allocation of Graduate Medical Education funds, including Senator Kassebaum's bill S. 1218, and I ask that you keep in mind our concerns, and certain principles we believe must be the critical underpinnings of a Graduate Medical Education system, as you consider all legislative proposals that may be debated in this session.

Meeting a National Need

The Massachusetts teaching hospitals are very pleased that the Health Security Act provides a separate funding stream for Graduate Medical Education, and that all pavers contribute to that fund. Our institutions serve a pressing national need, as educators of health care professionals, as leaders in producing biomedical research advances which have improved health care and the quality of life for patients throughout the nation, and as major providers of tertiary care. It is therefore appropriate for all payers to participate in the funding of that national mission.

We are especially appreciative of Senator Kennedy's efforts, on behalf of teaching hospitals and academic medical centers, in the development of these provisions. We know it is in large part due to him that the bill recognizes Graduate Medical Edu-

cation as a national need to be funded by all payers.

Issues of Concern

We do, however, have very serious concerns about the bill's Graduate Medical Education provisions, the proposed reduction in the Medicare Indirect Medical Education adjustment, and the bill's definition of "Academic Health Center." The Health Security Act's proposals in these areas require careful scrutiny and modification so that our ability to continue to provide the highest quality patient care, teaching, and research is not adversely affected. I want to emphasize, however, that while we are deeply concerned about the impact these provisions would have on our institutions, our support for the goals of this legislation remains unflagging. As we work out these differences and help revise and refine the legislation, we intend to remain focused on the many areas of agreement so we do not allow this unique opportunity to achieve systemic, comprehensive reform slip away.

#### REFORM AND THE MASSACHUSETTS TEACHING HOSPITAL ENVIRONMENT

#### Recent Trends in Massachusetts

Hospitals in Massachusetts have undergone significant change over the past two years. Some of these changes mirror those underway throughout the country. These include continued reductions in length of stay and improved ability to provide treatment in ambulatory settings, which have produced lowered occupancy rates in the short run, and bed closures in the longer run. Other changes unique to Massachusetts have made it a bellwether for future health care delivery nationwide.

Managed Care Enrollment Increase

Starting in 1991 with Chapter 495 and the onset of deregulation, the landscape of the health care system in Massachusetts began to change. Deregulation brought not only new opportunities, but also uncertainty and risks. Many hospitals have formed networks with other acute care institutions and with physician groups and health centers. My own institution, Brigham & Women's Hospital, recently agreed to what only a few years ago would never have been considered: an affiliation with Massachusetts General Hospital. Managed care enrollment has increased dramatically. As a result managed care plans' ability to negotiate with hospitals, in some cases unilaterally, has increased dramatically. Many managed care plans are now

unwilling to pay rates to teaching hospitals that fairly reflect the additional costs of teaching and research.

New Provider Relationships

The structure of reimbursement in Massachusetts has also changed and continues to change. Increasingly, managed care plans are expecting providers to assume more financial risk through capitation. This has forced hospitals and physicians to create new systems to monitor utilization and costs, and has caused hospitals and physicians to work more closely together. Providers have developed new relationshipsincluding, but not limited to, physician-hospital organizations—that enable them to share data and risk. It will take time for these new relationships to maximize their effectiveness on behalf of patients, but they offer great promise.

In addition to changes in the structure of reimbursement, reimbursement rates themselves have also dropped. These reduced reimbursement rates, coupled with falling admission rates, have compelled Massachusetts teaching hospitals to implement significant cost cutting measures-including, in some cases, layoffs-to remain financially viable. In order to minimize the impact of these measures on patient care, every opportunity to re-engineer the way care is delivered is being pursued.

Vulnerability to Further Cost Pressure

The objectives of these steps by Massachusetts hospitals, a highly efficient and less expensive system of health care delivery, leave these institutions at great risk in the event that further cuts are compelled by health care reform. Any legislative changes must be carefully considered in light of the difficult measures and reduc-

tions already undertaken.

It is critical that the resources offered by our institutions—in patient care, education, and research—not be compromised by lack of foresight. The desired effects of competition must be balanced with the interest of the entire nation in preserving what is valuable and unique about teaching hospitals, in general, and specifically what is valuable about Massachusetts teaching hospitals and their contributions to our region and our nation.

Adequacy of Graduate Medical Education Funding

The spectrum of costs associated with our academic mission makes it extremely difficult to compete in the current environment. Graduate Medical Education must

be adequately funded to cover our unique costs.

Our preliminary internal analysis shows that the Health Security Act seriously underfunds Graduate Medical Education, and that Massachusetts teaching hospitals could lose \$ 1.9 billion of Graduate Medical Education funding over five years due to reduced subsidies from all payers. We project that Graduate Medical Education support from Medicare will be reduced by \$1.2 billion between 1996 and 2000 and that Graduate Medical Education support form other payers will be reduced by \$700million over that same time period

While it is true that the total \$9.6 billion of Graduate Medical Education funds that teaching hospitals would receive under the Health Security Act exceeds the current \$6 billion paid by Medicare, that sum falls far short of our needs. The Medicare program supports only a portion of the academic mission. The remainder is obtained from public and private payers who provide the balance of funding for the additional costs associated with our mission of teaching, research, and patient care

through increased charges for those services.

For both of these pools, all payers would be required to contribute at a prescribed level. To project the loss of revenue to Massachusetts teaching hospitals for graduate medical education (DME and IME) from private payers, we have assumed that once such payers are required to contribute to the national pool for teaching, most, if not all, will reduce their payment rates to teaching hospitals to equal those paid to non-teaching hospitals. Cross-subsidization will cease.

A portion of this overall loss in Graduate Medical Education Funding results from the Health Security Act's basing payments for the Direct Medical Education Workforce Account on a national average per resident payment amount which in effect expands Medicare's current Direct Medical Education payment methodology to all payers. Our best information to date indicates that this per resident payment will only recognize the salaries and benefits of residents and attending physicians and will exclude all overhead costs associated with the training of residents. Medicare's current per resident payment amounts fall short of per resident costs. It is projected to be even lower under the reform proposal. Payments from private payers currently subsidizing the cost of direct medical education will consequently be reduced.

We ask that the bill provide increased funding for Graduate Medical Education.

# Medicare Reductions

The inadequacy of the funding in the Graduate Medical Education pools is compounded by the Medicare reductions proposed to help finance health care reform. Massachusetts teaching hospitals have estimated the reimbursement loss to us would be \$ 1.3 billion over five years. The greatest loss comes from the proposed reduction in the Indirect Medical Education adjustment, to 3.0 percent: \$727 mil-

Even when these losses are offset by our estimated anticipated gain from enact-ment of universal coverage, our losses from reduced Medicare reimbursement are about \$ 1 billion. Such large funding reductions, coupled with the inadequacy of

Graduate Medical Education funding, would cripple our institutions.

It does not seem rational to us that the Health Security Act in one section recognizes that Graduate Medical Education is a national need, deserving national support, and in another section eliminates more than half of the support we currently get. Given the very difficult and uncertain financial conditions that teaching hospitals face, such drastic reductions in Indirect Medical Education funding will have severe consequences. We urge that you not ask teaching hospitals to shoulder this disproportionately large share of the burden of financing health care reform.

Our additional concerns include the bill's definition of Academic Health Center, distribution of Graduate Medical Education funds under the bill, primary care training requirements, access to specialists, the National Council on Graduate Medical Education allocation system, and transition payments for lost specialty slots. Now

turn to those concerns.

# DEFINITION OF ACADEMIC HEALTH CENTER

We are gravely concerned about the bill's definition of "Academic Health Center." The Health Security Act is not at all clear about who is eligible for funds from

the Academic Health Center pool. It provides that funds from the pool are available to two entities, "academic health centers" and "teaching hospitals".

(1) An "academic health center" is defined as an institution which operates a medical school; operates or is affiliated with at least one of the following: a school of dentistry, pharmacy, optometry, podiatry, veterinary medicine, public health, or nursing; and operates or is affiliated with a teaching hospital.

(2) "Teaching hospital" is defined as "a hospital that operates an approved physi-

cian training program. We believe the Health Security Act's definition of an "academic health center" could make funds from the Academic Health Center pool, which are obviously intended to be Medicare Indirect Medical Education funds, available to entities for which they are not intended. Some have argued that this money should be available to medical schools. That is clearly contrary to the purpose of the Medicare Indirect Medical Education adjustment: to compensate for the costs of treating, and training residents to treat, patients who are more seriously ill and whose cases are more complicated than average. Diversion of these funds from their intended and appropriate purpose would be particularly harmful given the severe reduction of the Medicare IME adjustment in FY '96 and the reduced amount Medicare contributes to

the AHC pool, making the pool size inadequate even for those currently eligible. We urge that the bill specify that only an entity that actually incurs the cost of treating patients be eligible for funds from the Academic Health Center pool.

# DISTRIBUTION OF GME FUNDS

DME/Workforce Funds to "Programs"

We strongly oppose the bill's requirement that DME funds be paid to "programs" within Academic Health Centers. The purpose of DME funding is to compensate those who incur the cost of educating physicians. Residency programs do not incur those costs. Teaching hospitals, medical schools, and multi-specialty group practices sponsor the training programs; they incur the cost. We urge that the bill's provisions be amended to direct that funds flow "to the entity that incurs the cost" of educating physicians, rather than to individual "programs."

#### PRIMARY CARE TRAINING

#### Unrealistic Timetable

There is a clearly demonstrated national need for more primary care physicians. The Health Security Act's increased emphasis on managed care and preventive care services will increase the call for primary care physicians. We support that national goal, and are making a concerted effort to move in that direction. However, the Health Security Act's proposed implementation schedule, which calls for a 55%/45% primary/specialty residency mix by 1998 is unrealistic. Experience has shown the extreme difficulty of accurately predicting the necessary number and distribution of physicians. I believe the failure of those estimates in the past indicates we should carefully consider specific targets and implementation dates. We urge you to change this timetable to a more realistic and appropriate goal so that workforce planning can go forward in a rational way, assuring the continued highest quality of all residency programs.

Allocation of Specialty Training Slots

The bill proposes to establish a National Council on Graduate Medical Education with the authority to limit the total number of physicians trained annually and the total number of residents in each specialty. (Section 3001) Starting in 1998, the Council would also have the authority to allocate residency slots to specific pro-

We recognize that it is necessary to increase the number of primary care physicians, and that this increase must come at the expense of specialty slots. However,

cians, and that this increase must come at the expense of specialty slots. However, it is vitally important that teaching hospitals continue to be provided the opportunity to train the highest quality physicians, be they in primary care or in the needed specialties, and we ask that the final version of the legislation ensure that. Further, we believe the bill should require that a Chief Executive Officer of a teaching hospital be included as a member of the National Council, joining the required members of medical school faculty. We're running the programs; we should be represented among those making decisions that will determine the fate of our programs.

# Transition Payments

The Health Security Act provides for transitional payments to institutions operating training programs that lose specialty training positions as a result of allocations by the National Council. Payments are made over a four-year period, and may begin in 1998. Payments in the first year are equal to the number of specialty positions lost multiplied by the national average salary for residents, and decline by 25 percent in each of the succeeding three years.

We support inclusion of these transition payments. Massachusetts teaching hospitals expect to be among those institutions that will lose some specialty training slots, and transition payments will be critical to our ability to meet health care

needs under a new system.

We believe, however, these transition payments are too little, too late. The amount of transition payments should be increased, and they should be available immediately.

# Amount

The payment, if it is to be meaningful, should cover more than residents' stipends. Even if the size of a residency program is decreased, our institutions continue to incur related costs of faculty salary and overhead. We will need a period time to reallocate or reduce those costs. We will certainly incur the cost of hiring professionals to provide the care previously provided by our residents.

We ask that transition payments be increased and made available immediately.

#### CONCLUSION

The Massachusetts Teaching Hospitals stand firmly in favor of health care reform. The introduction of the Health Security Act affords a unique opportunity to accomplish much-needed reform of the health care system. The Massachusetts hospitals recognize that comprehensive reform is the only way our nation can achieve that goal, including universal access to quality care. We appreciate the vision and attention to detail of the proposed legislation. We ask that you cautiously approach any legislative changes in light of the uncertain environment in which we currently operate. We hope you will work with us to preserve what is valuable and unique about the Massachusetts teaching hospitals so we can continue to contribute to our region and our nation. The proposed Graduate Medical Education funding reductions, if enacted as proposed, would cripple our ability to perform our teaching, research, and patient care mission.

We ask that you keep our concerns in mind as Congress debates the Health Security Act and the various health care reform proposals under consideration.

PREPARED STATEMENT OF DR. REED V. TUCKSON Mr. Chairman and members of the Committee, please allow me to thank you for the opportunity to present the views of the Association of Minority Health Professions Schools (AMHPS) related to Health Care Reform and the training of health

care personnel.

As an organization comprised of the eleven Historically Black Health Professions As an organization comprised of the eleven Historically Black Health Professions Schools in our country, AMHPS is critical to any efforts to reform the health care system. Our member schools [Meharry Medical and Dental Schools in Nashville, TN; Morehouse School of Medicine in Atlanta, GA; the Charles R. Drew University of Medicine and Science in Los Angeles, CA; the Colleges of Pharmacy at Xavier University of Louisiana, Texas Southern University, and Florida A&M University; the Howard University's Schools of Medicine, Dentistry and Pharmacy in Washington, D.C; and the Tuskegee Alabama University School of Veterinary Medicine] train, to an extraordinary extent, the providers who are dedicated and competent to serve in underserved communities. For example; our four medical schools, four colleges of pharmacy, two dental schools, and one school of veterinary medicine have colleges of pharmacy, two dental schools, and one school of veterinary medicine have trained 50% of the nation's black physicians, 50% of the nation's dentists, 75% of the nation's black pharmacists, and 75% of the nation's black veterinarians. Most of the graduates of our institutions are working in the nation's underserved rural and inner city communities—the very communities that the Administration hopes to have the greatest impact upon with it's health care reform package.

In addition to the numbers of providers that we train, we are working within our institutions and as a collaborative consortium of institutions to develop innovative comprehensive health care teams that are able to more cost effectively address the

complex health status of socio-economically challenged communities.

# THE UNDERREPRESENTATION OF BLACKS AND OTHER MINORITIES IN THE HEALTH PROFESSIONS

Mr. Chairman, you should be concerned that despite the efforts of the past, the numbers of minority health professionals remains appallingly inadequate. In 1983 our Association commissioned a study to examine the status of minorities in the health professions. Even today, ten years later, the sobering findings revealed by that study, "Blacks and the Health Professions in the 80's. A National Crisis and A Time for Action", are still valid. Among them:

In the health professions in the United States, the ratio of black physicians and other health professionals to the black population has never been equal to the percentage of these health professionals in the white population.

While blacks comprise about 12% of the U.S. population, only about 3% of blacks are physicians, dentists, pharmacists and veterinarians.

Despite shortages of minority physicians and other health professionals in the U.S., these individuals are more likely than their non-minority contemporaries

to serve in underserved rural and inner city minority areas of the nation.

The severe shortage of blacks and other minorities in the health professions compound the health status and access disparity that exists among blacks and whites in this nation, because the very underserved areas that need the greatest attention are the least likely to be adequately served.

Projections of surpluses of physicians—and subsequent changes in federal policy-made by federal advisory bodies have had a disproportionately negative impact on the ability of minority health professions schools to secure the resources necessary to prepare and train more minorities in the health professions.

The conclusion is that we have made very little progress. This is a great concern because of the well documented health status disparity between blacks, other minorities and whites.

# THE HEALTH STATUS OF BLACKS AND OTHER MINORITIES

The 1983 study of minority health professionals commissioned by our association encouraged then HHS Secretary Margaret Heckler to conduct a comprehensive examination of the health status of minorities in this nation. While the rest of the nation celebrated a substantial gain in health status and life expectancy, during the 80's, blacks and other minorities experienced just the opposite. Recent Department of Human Services statistics show that since the 1985 "HHS Secretary's Task Force on Black and Minority Health" the disparities in the health status of minorities has not improved:

Life expectancy of black males and black females is 8.2 and 5.8 years shorter, respectively than for their white counterparts; Among blacks, infant mortality occurs at a rate of 20 per 1,000 live births, twice that of whites; Blacks suffer disproportionately higher rates of cancer, cardiovascular disease and stroke, chemical dependency, diabetes, homicide and accidents, and infant mortality; and Each year over 70,000 excess deaths occur among blacks when compared

Mr. Chairman, the mid 80's Secretary's task force did not feature any part of the current AIDS crisis that faces blacks, nor did it significantly discuss the emerging issues of death and morbidity by violence. Based on these statistics it is especially obvious how urgent health reform is for blacks and other minorities.

#### HEALTH CARE REFORM AND THE MINORITY COMMUNITY

African-Americans and other minorities hold a tremendous stake in the outcome of health system reform due to the fact that a disproportionate number of the nation's population that is not well served by our current system are minorities. While approximately 18% of all Americans lack health insurance, 25% of African-Americans and 35% of Hispanics are represented among the uninsured. Blacks and other minorities suffer disproportionately from a lack of access to health care as reflected in the number of excess deaths and prolonged illness for treatable conditions. Similarly, the lack of access to prenatal care and immunizations manifests itself into excess maternal-infant deaths and excessive childhood diseases.

But remember that access to health insurance does not necessarily equal access to health care. There must be providers available in all communities, especially inner-city and rural areas. Providers trained to handle the complex health problems of such communities are desperately needed. Our schools have accumulated a legacy of experience in training health professionals and developing new knowledge in service to such communities. When precious few others were interested or saw it as their duty to be concerned about poor people and those who are uninsured, we

Now that health reform has, at long last, a real opportunity to be realized, we are by turns excited and fearful. We are excited that opportunities now exist for our patients and thereby, our facilities, to have access to the financial support so necessary to the delivery of quality health care. We are excited that there is appreciation for primary health care providers and comprehensive health teams that are trained in community and rural practice environments. And we are excited by the opportunities for support for the development of new knowledge in the provision of

health care to underserved communities.

We are concerned however, that health reform could mean that it would become difficult or impossible for us to compete for patients against more heavily capitized entrepreneurial providers who will "suddenly" become interested in our patient base. Because much of the health system reform debate has focused on providers of health care services, we believe it is important to note the plight of providers in underserved, rural and inner city communities who are constantly faced with the burden of providing care to indigent persons who have no form of health insurance and to recipients of Medicaid, which reimburses at a significantly reduced rate than does private insurance. In effect, minority health professionals, many of them graduates of our institutions, are subsidizing the care of people who are uninsured and underinsured. Because the majority of their patients fall into this category, there is no one to which costs can be shifted.

In addition, it is imperative that the plight of hospitals in underserved rural and inner city communities, that provide care to persons who are uninsured or underinsured, be carefully addressed in the reformation of our nation's health care system. Since 1961, almost 100 historically black hospitals in this country have closed and today, only twelve (12) remain. All are victims of a mission of providing

care to the poor, with inadequate infrastructure support and reimbursement.

#### HEALTH CARE REFORM AND THE MINORITY PHYSICIAN WORKFORCE

Our second concern is that while we are extremely enthusiastic about the need for increasing the numbers of primary care providers, we also are aware that minority and underserved communities do not have nearly enough specialist physicians

to meet their incredible health needs.

Lastly, the shortages of minority physicians described in our 1983 study were reviewed again in 1992 by the Council on Graduate Medical Education (COGME), chaired then by the current CDC Director, Dr. David Satcher, who at that time was the President of Meharry Medical College, an AMHPS member institution. COGME reaffirmed the significant shortages of minorities in the physician workforce, and also demonstrated that the shortage does not exist only among primary care specialties. There is a severe shortage of black physicians in all medical specialties. We are concerned that the funding support for Medical Education may not be adequate or flexible enough to support the innovative training programs in community based primary care multidisciplinary settings.

This problem leads our association to question the total focus of a revised system that establishes strong barriers and disincentives for all physicians to seek careers in medical specialties. While the overall trend of creating a better balance between primary care and specialists physicians may be appropriate for 80% of the population, the other 20% of the Nation's citizens are dramatically in need of minority

physicians trained in primary care and in various medical specialties.

The Council on Graduate Medical Education's 1993 Report made a series of well thought-out recommendations that would insure maintenance of the overall goal of increasing the number of primary care physicians, while insuring growth in all medical specialties (including primary care) for minority physicians. Our association encourages this committee to incorporate these recommendations into the Health Care Reform legislation. I will submit them to you for the Committee's consideration.

Currently, the COGME recommendations are not reflected in the President's bill.

### RECOMMENDATIONS

Therefore, Mr. Chairman:

AMHPS stress the urgent passage of universal health reform. It must be established as quickly as possible so that we do not experience another 70,000 un-

necessary deaths.

AMHPS urges that specific funding be directed towards realizing the goals in the President's health reform package and that it include the initiative, embraced by the academic health sciences community, to train 3,000 minority health professionals by the year 2,000. This means support for the development of minority science expertise beginning as early as elementary school, through the junior and senior high school levels and including supportive programs for college students.

AMHPS wants targeted funding to support minority academic health science centers to enable them and their clinical teaching facilities to successfully com-

pete for their patient base.

We urge Congress to provide much needed support for the development of new knowledge in the provision of health services to underserved communities that enhances the national capacity to prevent disease, promote health, make more cost effective and diagnostic judgements and therapeutic decisions in socio-economically challenged populations.

We want greater support for our students, in terms of academic preparedness,

scholarships, financial assistance and loans.

Again, Mr. Chairman, thank you for the opportunity to present the views of AMHPS. I am pleased to answer any questions you may have.

#### PREPARED STATEMENT OF EDWARD H. O'NEIL

While current efforts to reform our health care system focus on transforming finance and delivery structures, no significant change will take place without dramatic alterations in the health care workforce. The nation's ten million health care practitioners have an enormous impact on the cost and quality of health care and access to the health care system. With appropriate reforms, this workforce can be-

come the foundation for an efficient, high quality, and equitable new system.

The health care workforce is comprised of a broad array of professionals, including dentists, nurses, pharmacists, physicians, physician assistants, and other allied health professionals. In addition, there is a critically important but ill-defined group of community care providers working largely in informal settings. All of these individuals are essential to the system of health care, and as this system is reformed it is of fundamental importance that policies are developed to insure that professionals from each of these disciplines are available in sufficient number and distribution to meet public demand. In addition, members of a number of these professions provide important first-contact health care. Dentists, pharmacists, podiatrists, and psychologists, for example, each may often provide initial care for individuals health problems.

The current health care reform debate has as its central concern our ability to provide all Americans with access to quality health care while restraining the growth in the costs of care. Although each of the health professions can contribute to the solutions for this problem, it is clear that the major issues of cost and access reside in the medical care system, and it is here that most attention of federal policy has been turned. Specifically, current federal policy debates, and this paper as well, primarily address issues related to the training of physicians, nurses, and physician assistants. The training of dentists, dental hygienists, pharmacists, physical therapists, and others is also an appropriate concern for federal policy, and recommendations will be made in future papers. However, it is our fundamental position that changes in the support of the medical workforce must not come at the expense of other components of the broad health care system. It is particularly important that federal money appropriated to support the training of other health professionals not be redirected to finance any additional needs with respect to the training of the new

workforce of physicians, nurses, and physician assistants.

Although there are significant variations by region and by state, nationally the current medical care system supports a workforce which is dominated by medical specialists. Uncoordinated patient access results in fragmented and costly service as patients often seek care from various specialists. A reformed system should strive to streamline patient access, coordinate service delivery, and promote cost efficiency—in other words, to "manage" patient care better. Any managed system will require a greatly expanded primary care orientation and workforce, including family physicians, general pediatricians, general internists, nurse practitioners, physician assistants, and certified nurse midwives. These practitioners can work both independently and in teams to provide cost effective care, coordinate referrals to specialists, emphasize health promotion and disease prevention, and incorporate individual, family, and community health.

Much of the evidence for the advantages of a primary care system have been drawn from small studies and international comparisons. The success of primary care-based systems has been exhibited in many other countries and most recently in a cross national study among seven major industrialized nations (Starfield, 1991). A consensus has emerged from these studies that a primary care-based system would contribute significantly to reduced costs, expanded access, and improved qual-

ity of care.

Increasing the primary care workforce in the United States requires breaking tradition with the past policies that have shaped health care and professional education. First, there must be integration of federal, state, and institutional efforts, with significant federal leadership. Second, reforms must not focus exclusively on changing the relative numbers of various primary care professionals as past health care manpower programs have done. New proposals must knit together changes in the availability of workers with changes in their skills, competencies, and practice environments. Third, reforms must thrive in the new political and economic environment emerging from the Clinton Administration. The new economy demands that existing policies and programs be evaluated for effectiveness and that as necessary resources be redirected to advance more creative and less costly solutions.

Over the past three years, Phase I of the Pew Health Professions Commission focused on reforming health care and health professions education in America. This paper draws on the Commission's work and makes specific federal policy recommendations related to a primary care workforce. Phase II of the Pew Commission, which began its work this September, maintains that health professional institutions must prepare all health care providers, not just primary care practitioners, with the skills, competencies, values and attitudes necessary to work in a reformed system. The following list summarizes the competencies that the Pew Commission believes will be required of those working in the emerging health care system.

[Additional material is retained in the files of the committee.]

#### STATEMENT OF KRISTEN GARDNER AND MARY BETH LOVE

Worldwide, primary health care delivered by Community Health Workers is the simplest, safest, and most inexpensive medical and public health measure providing direct and essential health care to underserved populations. A joint UNICEF-WHO conference on Primary Health Care defined primary health care as the bridge between existing health care services and communities in need: primary health care is "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and their families in the community through their full participation at a cost that the community and country can afford." Community Health Workers (CHWs) have been integrated internationally into efforts to provide primary health care.

As some United States health indices are proving to be comparable to those of developing countries and access to care is a growing problem for certain disadvantaged segments of our citizens, there is a greater awareness of the need for a different approach to health care. This is compounded by the high cost of health care and simultaneously shrinking public funds. Community Health Workers have been and increasingly can be a route through which to address these issues by providing culturally appropriate and cost effective health services. The training and employ-

ment of CHWs also provides employment opportunities for members of disadvantaged communities.

CHWs are links between their community and the health care system. They are often indigenous to the community in which they work, providing a unique understanding of the needs and strengths of the community they serve. They can provide appropriate information, referrals, services and advice on how to access existing services. CHWs focus on preventive and primary health care. They get individuals and communities involved in their own health at a point that can reduce the demand on more expensive care in the future.

The ability to connect communities and existing services is a unique skill that needs to be recognized, fostered, and integrated into health care planning. As a member of the health care team, they can serve as invaluable assets in the development of effective health services and programs. By supporting the training of individuals in this field of work we are validating their role in the health care system

Working as a CHW is a career goal for some and an entry into the health care field for others. Supporting CHW training is a way to support disadvantaged individuals in finding employment and increasing the numbers of disadvantaged individuals in the health care field.

At this time Calilornia has no unified, systematic training program for the expanding role of CHWs. Novice CHWs are employed with little or no training in primary health care or community outreach. Many agencies forego or postpone recruitment because of the added supervision burden of untrained workers.

In San Francisco, the Community Health Worker Training Program has been developing and implementing a competency-based training at the Community College level. The goals of the program are (1) to improve the primary health care provided to disadvantaged and bilingual communities by increasing the number of CHWs equipped to provide culturally and linguistically appropriate services and (2) to serve as a step to college/career pathway to increase the number of disadvantaged individuals who choose baccalaureate and graduate programs in health care and public health fields.

We have developed a year long curriculum that includes academic and field work components addressing basic CHW skills and knowledge. The program focuses on training individuals from disadvantaged backgrounds interested in working in their communities. Each participant receives 10 college credits and a certificate of comple-

tion. This model is meant to be replicated in community colleges across the state.

In our work we collaborate with the Northern California Community Health
Worker Training and Policy Coalition. This coalition is includes other training programs, supervisors and employers of CHWs, and a number of CHWs who are concerned with the training and employment of CHWs. The goals of the Coalition are to (1) define uniform standards for training CHWs, (2) make recommendations regarding the certification of CHWs, and (3) act as policy advocates for the effective and respectful training and employment of CHWs.

We strongly encourage Federal recognition and support for Community Health Workers in the areas of training and employment. We believe that they are crucial to creating a health care system that meets the needs of all citizens. happy to provide further information or assistance in the area of CHW training and

employment.

## PREPARED STATEMENT OF DR. STUART BONDURANT

Mr. Chairman and members of the subcommittee, I am pleased to appear before you today to comment on two proposals of particular interest to academic medicine in the Health Security Act, S. 1757, (HSA). I am Stuart Bondurant, M.D., Chairman of the Association of American Medical Colleges (AAMC) and Dean of the University of North Carolina at Chapel Hill School of Medicine. The AAMC represents the nation's 126 accredited medical schools, 400 major teaching hospitals, the faculty of these institutions through 92 constituent academic society members, and the more than 140,000 young men and women in medical training as students and residents.

The AAMC appreciates the administration's leadership in initiating legislation to extend universal comprehensive health coverage while improving quality and constraining growth in health care costs. Mr. Chairman, the association commends your long-standing commitment to these goals as well. As early as 1969, the AAMC called for universal access to health care, and since then has advocated a number of other positions on reform of the overall system, including the need to: balance the provision of a basic benefits package with available resources; provide access to primary, preventive, and specialty care; support pluralistic financing systems with appropriate beneficiary cost sharing mechanisms; and develop planned community health care programs.

in June 1993, the association adopted a set of five goals and supporting principles that should guide health care reform. These goals are: 1) giving all Americans the chance for a healthy life; 2) providing universal access to health care; 3) recognizing that once health care excellence is achieved, the necessary resources must be provided so that quality and capacity are maintained; 4) instituting cost containment measures that do not compromise health care quality; and 5) supporting the essential roles of medical and other health professional education and of biomedical, behavioral and health services research. (Appendix A provides a complete list of goals

and principles.)

Health care reform will test the entire health care system, and academic medicine in particular will face special challenges. These institutions and their faculties constitute the cornerstone of the health care system, as educators of physicians and other health professionals, creators and evaluators of scientific knowledge and its transfer into practice for the benefit of society, and major providers of primary, secondary and tertiary care in their local communities—often to indigent patients—and on regional, national and international levels. These special responsibilities are highly interdependent in both their missions and financing, and increase the costs, and therefore the price that teaching physicians and teaching hospitals must charge for their services, making it difficult or impossible for them to compete in a price conscious environment. Additionally, the contributions of academic medicine depend on multiple sources of financing, each of which is increasingly constrained. If medical schools and teaching hospitals are to sustain their roles as ultimate guarantors of the effectiveness of the health care system, health care reform must recognize the

special roles these institutions play in society.

The AAMC is interested in may issues in the proposal, ranging from broad areas such as anti-trust, to more narrow concerns, such as the provision for contracting with academic health centers. There are many policies in the HSA that deserve enthusiastic support, ranging from reforming the Medicaid program to altering the malpractice system. The AAMC is particularly pleased that the HSA recognizes the critical missions of teaching physicians and teaching hospitals in the health care system: educating physicians, research scientists and other health professionals; developing new medical technology; treating rare and unusually severe illnesses; providing specialized patient care; and caring for special populations. However, the association must call to the attention of this committee and others that the HSA, as proposed, represents a severe threat to the financial viability of the nation's medical schools. Medical school financing is based on a fragile structure of internal crosssubsidies; a very substantial portion of medical school expenses are borne by revenue derived from patient services provided by medical school faculty members. Managed competition, by creating a medical care market highly sensitive to price, will tend to reduce revenues available for this purpose. Simultaneously, it will demand radical shifts in educational emphasis, from specialist to generalist, from hospital to ambulatory focused care. Thus, traditional revenue generating activities will be curtailed or become less rewarding while revenue consumptive activities will increase. Faculty income promises to be reduced, while greater reliance for educational purposes must be placed on community physicians. The income of community physicians will be constrained and medical schools will be without income to compensate them for the additional contributions to professional education asked of them.

Currently, the HSA makes no provision for revenue lost to medical schools, no provision for supporting costly new activities that must be undertaken and makes no allowance for a transition to a new and highly uncertain future. Thus, as a medical school dean, I and my colleagues anticipate health care reform with considerable

trepidation.

The legislation's provisions for physician workforce priorities, academic health centers (AHCs), health research initiatives, health programs of the Department of Veterans Affairs (VA), and hospitals serving vulnerable populations give the association a opportunity to continue a dialogue in these areas. They are of special concern to academic medicine and are crucial to the overall viability and quality of the health care system. Today I will focus my comments on two specific provisions in the legislation: the health professions workforce and the academic health center proposals. I will then return to the theme of the financial viability of medical schools.

The HSA has an underlying policy requiring support for the missions of academic medicine from all insurers or sponsors of patient care programs. The level of financial support, the purposes for which the funds are intended, and how money is allocated are all matters that will be subject to debate. However, the AAMC wishes to emphasize the fundamental importance of the principle that all payers must support education and the training of the workforce as well as providing an environment in

which education and clinical research can flourish. Our commitment to this principle will not waiver.

THE HEALTH SECURITY ACT: THE WORKFORCE PLANNING AND ALLOCATION PROVISIONS

Summary of the Act. The HSA would establish a national council on graduate medical education within the Department of Health and Human Services (DHHS) to designate annually the total number of residency training positions in each specialty and allocate positions to approved training programs. The national council, to be appointed by the Secretary of the DHHS, would include consumers, medical school faculty and other practicing physicians, and officers or employees of regional and corporate alliances and health plans.

The national council would make its first annual designation of training positions in each specialty for the three-year period beginning July 1, 1998, notifying programs of their approval no later than July 1, 1997. At least 55 percent of the class entering residency training in July 1998 (and classes thereafter) must, in the aggregate, complete training in the primary care specialties of family medicine, general internal medicine, general pediatrics and obstetrics/gynecology. Thus, 55 percent of the physicians starting their graduate training in 1998-99 would complete their training at the end of the 2000-01 academic year as generalists.

training at the end of the 2000-01 academic year as generalists.

For each of the academic years 1998-99 through 2002-03 (a five-year period), the national council also would adjust the total number of positions by a percentage that it would determine. The HSA states that the annual number of positions should bear a relationship to the number of U.S. allopathic and osteopathic medical school

graduates in the preceding academic year.

In making its annual designation of the number of positions, the council would consider the need for additional practitioners in each specialty based on the incidence and prevalence of diseases and disorders with which the specialty is concerned; the number of practicing physicians in the specialty currently and five years from the start of the academic year; and the recommendations of physician specialty and consumer groups. The council would allocate positions based on the historical distribution and quality of training programs; the extent to which programs train under-represented racial and ethnic minorities; and the recommendations of private physician specialty and consumer organizations.

#### AAMC COMMENTS ON WORKFORCE PLANNING AND ALLOCATION PROVISIONS

The Need for Generalists. The AAMC agrees with the need to train more physicians in the generalist disciplines, one of the basic principles underlying the HSA. Increasing access to the health care system for all Americans will require more generalist physicians. In 1992, the association called for a national goal of a majority of graduating medical students committing to generalist careers in family medicine, general internal medicine, and general pediatrics.

However, the AAMC believes that a regulatory approach to physician workforce training might not be necessary. Changes in market forces already are shifting the balance of generalist and specialist physicians as incentive systems are restructured, and it appears likely this trend will continue. Changes in the practice environment, namely the increase in managed care arrangements, increases in physician reimbursement for cognitive services, and mitigation of the "hassle factor" are

also likely to affect medical students' career choice.

Although data on medical students' career choice from as recently as the graduating class of 1989 show a declining selection of the generalist specialties, more recent data give the AAMC and the academic medical community signs that 1993 medical school graduates have noticed the changes in the environment. This year, for the first time a more than ten years, the percentage of medical school graduates indicating their intention to pursue certification in one of the generalist disciplines increased. Of graduating medical students, 19.3 percent indicated an intent to choose a generalist career in 1993 compared to 14.9 percent in 1991 and 14.6 percent in 1992.

If, on the other hand, an all-payer fund for the costs of training the physician workforce is created and analysis has shown that market forces have not been effective in shifting the balance of generalist and specialist physicians and in achieving appropriate goals for the total number of residency positions, then the AAMC would support a regulatory approach to physician training. A national commission or council could assume responsibility for authorizing payment from the fund for the costs

of graduate medical education to assure that national goals are met.

The Need for a Planning Process. The AAMC recognizes the need for a permanent and continuous physician workforce planning process at the national level. The successful implementation of health care reform rests upon an adequate supply of well-

trained health professionals in an appropriate specialty mix that addresses the

needs of the population.

The association supports the creation of a national physician workforce council or commission, authorized in statute, that would be composed predominantly of private citizens representing various constituencies with interests in physician education. However, we strongly support the addition of medical school deans and teaching hospital executives to the membership of the HSA's proposed national council. The administration's proposal does not now include these categories for representation.

We also believe that the national council should be independent of the DHHS and funded separately from the workforce account. The AAMC is currently considering options for how the council or commission could be structured and organized. Our concerns are whether this body would be advisory or the locus for all responsibility concerning graduate medical education and whether the council would be insulated appropriately from attempts to influence its decisions. Additionally, the council would need sufficient funding and staff to permit its effective operation.

The AAMC is concerned that the timetable for making the council operational

may be too ambitious. The HSA requires that training programs would have to be notified of their approval by July 1, 1997. If the HSA were signed into law in August 1994, the national council would have less than three years to establish and organize itself, adopt broad principles and policies for change, and make thousands

of allocation decisions.

Determination of the Number and Allocation of Residency Positions. As in the HSA, the association endorses no specific number or limit on the total number of positions, but expects ding capacity to relate to projected physician need and the number of U.S. allopathic and osteopathic medical school graduates. The AAMC believes that the commission should assess physician workforce needs and provide guidance for setting goals for the total number and specialty mix of residency posi-tions. We agree with the administration that in designating the annual number of positions, it would be desirable to consider the current and future distribution of practicing physicians, and the incidence and prevalence of diseases associated with particular specialties, among other factors.

The AAMC believes that implementing the achievement of the 55/45 ratio by the

year 2001-02 is much too aggressive. As currently described in the HSA, the national council would adjust the specialty mix of first-year positions for the 1998-99

entering residency class, which would be required, in the aggregate, to complete their training in a 55/45 generalist-to-specialist ratio by 2001-02.

The AAMC also is concerned that the timetables for allocating positions by specialty and for adjusting the total number of residents are poorly coordinated and are too rapid to permit institutions to adjust their training program size and mix. At the same time the council would adjust the specialty mix of first-year positions to a 55/45 generalist-to-specialist ratio, the council also would begin to reduce the total number of residents in 1998-99 for the first reduction over a five-year period (through 2002-03). Assuming a policy of first-year positions equal to 110 percent of U.S. allopathic and osteopathic medical school graduates, the national council would be placed in the position of advocating or directing an increase in the number of generalist positions, only to have to eliminate some of them later to achieve a reduc-

tion in the overall number of first-year residency positions.

Table 1 below uses current (1992-93) data to demonstrate how the number of generalist and specialist first-year positions would change if this limit were placed on the total number of residency positions. In this example, the overall limit is 18,660 positions, roughly the number of graduates of U.S. allopathic and osteopathic medical schools plus ten percent. The number of first-year generalist positions would have to be increased dramatically in 1998-99, but then would have to be decreased to limit the overall number of positions to 110 percent, while maintaining the 55/45 generalist-to-specialist ratio. This example assumes that the 110 percent goal of 18,660 first-year positions would be reached in 2002-03 through a gradual, annual reduction of about 850 positions over a five-year period beginning with the 1998-99 entering residency class.

Although the AAMC recognizes that there is an immediate need to adjust the size and specialty mix of the physician workforce, the training period for physicians is long. Any adjustments in aggregate and in specialty-specific training capacity should be carefully planned and coordinated 50 that the quality of the educational experience will not diminish and that teaching hospitals and training programs will be able to adapt to the requirements of the new system. One way to limit the number of residents and shift the specialty mix would be to encourage voluntarism among the specialties. The national council, early in its operations, could designate national goals or targets for each specialty. The private sector would then be able to determine its own methods for reaching the goals. Whether the specialties could meet these targets in a hostile legal environment, however, is unclear. Particularly in the area of workforce planning, and in many other areas as well, where societal needs might be better and more efficiently met by a coordinated effort among academic institutions and health care organizations, the watchful eye of the antitrust enforcers of the Federal Trade Commission and the Department of Justice casts a pall over the potential for joint endeavors. Wherever institutions, professionals, or professional societies might be regarded as actual or potential economic competitors, the current state of the law, perversely, precludes private sector efforts, and forces constructive initiatives to be the sole province of government. Thus, to accomplish its objectives, the HSA must address legislatively the boundaries of antitrust law

and its enforcement in the health care arena.

If an allocation methodology is necessary, however, the AAMC proposes that the timetable as described in the earlier draft version of the HSA is more reasonable, providing institutions with the opportunity to adjust their training program size and mix and allowing time for market forces to shift the balance of generalists and specialists. As described in the earlier draft version of the HSA, 55 percent of the class that enters residency training in academic year 2002-03 would be required to complete their training in generalist disciplines. The council would reduce the total number of residents by a percentage for each of the academic years 2003-04 through 2007-08. The provision of a transition period from 1998 until 2002 would be required to the described by the describ tutions the flexibility to determine how to achieve the phase-own or closure of a training program as long as they achieved the goal by the end of the three- to sevenyear time period depending on the specialty.

The national council could inform institutions and ding programs of the size and mix targets that should be met by the end of a determined period, rather than annually, so that they could devise and implement their own strategies for adjusting training program size and mix. A series of annual decisions over a five-year period would cause significant disruption and uncertainty by requiring institutions to respond incrementally. While adoption of the timetable in the earlier draft would mean aggregate changes in the number of residents would not be completed until 2007-08, compared to 2002-03 in the current version, we believe this method would be a better approach than the current version of the HSA, both for the nation's workforce planning process and for current sponsors of training programs.

if an all-payer fund has been established and the academic medical community agrees to accept an allocation process because market forces have not had an adequate impact on shifting the balance of generalist and specialist physicians, the AAMC would support a process in which allocation decisions by specialty would be based on a variety of factors. Among the factors in the HSA are the historic geographic distribution of training programs, quality, underrepresented minority groups, and the recommendations of private health care and consumer organizations. The AAMC believes that educational organizations and associations, which often collect and analyze data on graduate medical education and other relevant topics, could make meaningful recommendations to the council concerning the allo-

cation of residency positions.

Even so, an equitable allocation system will be difficult to achieve. The structure of graduate medical education is complex. Graduate medical education is the period of formal education in clinical practice that begins with graduation from medical school and ends with the fulfillment of the requirements for certification in specialty or subspecialty practice. The training period for physicians is long. Each of 82 specialties and subspecialties has its own training requirements, and there are nearly 7,000 training programs. Any allocation system must be flexible. For example, some specialties or programs require residents to enroll first in a broad-based clinical year of training, often in internal medicine or pediatrics, before entering specialty training. Other trainees, about 6.5 percent of all first-year residents in 1992-93, may enter a first-year residency experience, often referred to as a transitional year, to obtain a broad-based clinical year because they may be undecided about their future discipline. How to count the first, and in some unusual cases a second, transitional year will become an important issue in how positions get allocated by specialty. Other trainees may not complete their training within the minimum required time because they train part-time, share a residency position, interrupt their training for childbearing or other reasons, or change the discipline in which they train. The allocation system must be designed to accommodate these factors.

Another issue of concern to the association is the length of period for which the Council would approve residency training positions in each specialty. The HSA would require the Council to determine which slots would be approved for a three year period. While this is the length of training for initial board eligibility in internal medicine, pediatrics, and family medicine, there are many programs which are longer than 3 years. For example, initial board eligibility in general surgery requires 5 years of training. Longer training programs would be disrupted if a program were notified in the third-year of a resident's training, that the program would no longer be funded. Therefore, the Council should designate positions, at a minimum, until

at least the period of initial board eligibility in each specialty.

A review of the concentration of specialties and location of training reveals some important points which can be understood by reviewing Tables 3-7 at the end of this testimony. While the majority of residents are concentrated in a relatively small number of specialties and states, the remaining residents are widely distributed. Residents, training in 25 specialty and 57 subspecialty areas, are concentrated in a relatively small number of specialties. Table 3 shows that nearly one-half of all physicians in training are in the specialties of internal medicine, pediatrics and surgery. Residency training programs are unevenly distributed across the nation. Table 5 shows that while 48 states have some residents in training, one-half of all residents are trained in seven states. With this heavy concentration but broad dispersion of residents, policy makers will have to consider carefully the impact of proposed policies on both the large concentrations as well as the broader distribution in designing an allocation system.

While the AAMC concurs that quality should be a major factor in the allocation process, the association has several concerns about the process for stratifying training programs by quality. One is that there would have to be a process in place by which new training programs could enter the system. In addition, there would need to be a process to address fluctuation in individual program quality across years. Educational quality is dynamic. The process and incentives must be in place to motivate the program to improve its quality continuously, rather than simply taking a snapshot of educational quality. Finally, one must make the distinction between the significant reductions in positions that are likely to occur in the first five years after the proposed legislation is passed compared to the continuous monitoring of educational quality that will be needed in later years. The decision of whether to eliminate a training program entirely or whether merely to reduce the size of the

existing program may require very different approaches.

A large number of professional organizations participate in graduate medical education to provide control over the quality of the training. They determine the standards to be met by each type of specialty training program and assess whether or not individual programs meet the standards. The Accreditation Council for Graduate Medical Education (ACGME) accredits nearly 7,000 graduate medical education programs in the United States. It is sponsored by five parent organizations, including the AAMC. The ACGME relies on residency review committees (RRCs) to perform the actual review of each training program. A RRC consists of representatives from the specialty appointed by the appropriate specialty board, and in some cases, a national specialty society, and the American Medical Association. Residency programs are accredited either by the ACGME upon recommendation of the RRC or by the RRC itself, if the ACGME has delegated authority or the American October 1980 and 1980 and 1980 are relieved to the Accommendation of the RRC states and the supergraph of the ACGME of the Accommendation of the RRC states are relieved to the supergraph of the Accommendation of the RRC states are relieved to the supergraph of the Accommendation of the RRC states are relieved to the supergraph of the Accommendation of the RRC states are relieved to the supergraph of the Accommendation of the RRC states are relieved to the supergraph of the Accommendation of the RRC states are relieved to the supergraph of the supergraph of the Accommendation of the RRC states are relieved to the supergraph of the Accommendation of the RRC states are relieved to the supergraph of the Accommendation of the RRC states are relieved to the supergraph of the Accommendation of the RRC states are relieved to the supergraph of the Accommendation of the RRC states are relieved to the supergraph of the Accommendation of the RRC states are relieved to the supergraph of the Accommendation of the RRC states are relieved to the supergraph of the Accommendation of the RRC states are relieved to the supergraph of the Accommendation of the RRC states are relieved to the supergraph of the Accommendation of the RRC states are relieved to the supergraph of the Accommendation of the RRC states are relieved to the supergraph of the Accommendation of the RRC states are relieved to the supergraph of the Accommendation of the RRC states are relieved to the supergraph of the Accommendation of the Accommendation of the Accommendation of the Accommendation

Some policy makers have suggested that the ACGME or the American Osteo-pathic Association's Committee on Post-doctoral Training, which would be separate from the proposed national council, should assume the additional and sole responsibility of allocating positions on the basis of measures of educational quality. The association believes that the medical profession should judge the quality of its training programs, but it has several concerns about the ACGME's ability to differentiate and stratify dining programs by educational quality. For example, it is unclear whether the ACGME has the information systems or methodology to quantify educational quality objectively beyond established minimum criteria. To rank training programs would be highly subjective. In addition, the structure and resource level of the ACGME may be inadequate to undertake this role. Developing and implementing a mechanism to stratify programs by quality certainly would require more staff and financial resources than the ACGME currently has at its disposal. It is also clear that, if the ACGME were to take on the role of ranking training programs by quality, it and its five sponsoring organizations would need significant legal protection. The ACGME relies almost wholly on contributed professional time. Thus, it is not structured to command the resources to deal with the inevitable legal chalthe shot structured to command the resources to dear with the inevitable legal challenges to a ranking process that will accumulate over time. The role of quality in the allocation process and the method of measuring program quality are difficult is sues. While the AAMC's current position is that the ACGME should not assume responsibility for allocation or ranking, the association also recognizes that there are strong arguments favoring some greater level of participation by the ACGME in an allocation process. The AAMC, along with other sponsors of the ACGME, is currently evaluating an ACGME proposal on how the ACGME could effectively and approprietably participate in allocation activities. propriately participate in allocation activities.

The AAMC strongly supports considering underrepresented minority groups in position allocation decisions. The association has implemented an initiative aimed at increasing the number of underrepresented minorities who apply to medical school.

Called 3000 X 2000, our goal is to have 3,000 individuals in underrepresented minorities apply to U.S. medical schools in the year 2000.

The AAMC believes there are a variety of allocation approaches to study. We hope that the HSA provides the national council with the flexibility to examine a number of national, regional and local approaches. Dr. Lee and his staff have been very gracious in consulting with the AAMC on this and other workforce issues. We have provided data on residency training to the Public Health Service in the Department of Health and Human Services and hope to continue working with Dr. Lee's representatives to help them refine their proposals. Before I comment further on the workforce provision, I would like to address the overall financing adequacy of the workforce and academic health center provisions.

#### THE HEALTH SECURITY ACT: SUMMARY AND GENERAL COMMENTS ON FINANCING PROVISIONS FOR THE WORKFORCE AND AHC ACCOUNTS

Summary of the Act. The HSA would recognize the critical roles of academic medicine in the health care system by creating two funds. The physical workforce account would assist in the funding for the institutional costs of graduate medical education; the academic health center (AHC) account would assist these institutions and teaching hospitals in covering the special costs they incur as part of their academic mission. Both funds would be separate from patient care revenue and, according to the administration's December 1993 analysis of the HSA, three sources—the Medicare program, regional health alliances and corporate alliances—would be required to contribute to both funds.

AAMÇ Comments on Overall Financing.

The AAMC is pleased that the HSA recognizes that teaching hospitals and teaching physicians are unique national resources and that they have added societal responsibilities in the health care system. The association strongly supports the need to fund separately the spectrum of costs associated with I academic mission, including the costs of graduate medical education and other health professionals, and the special and unique patient care costs that make it difficult for these institutions to compete in the current environment. We also agree that all payers should contribute

to the financing of both accounts.

However, the AAMC is concerned about the level of the financing of the two accounts and how the funds are distributed. Overall, the amount available to fund these costs is insufficient. Proponents of the HSA have argued that, if enacted, teaching hospitals would be better protected and more adequately financed than if the current situation were maintained. They compare the current level of Medicare payments for direct graduate medical education and indirect medical education costs-nearly \$6 billion in FY 1994-to the \$9.6 billion total amount that teaching hospitals would receive in the year 2000 under the HSA. In addition, many HSA-proponents believe that teaching hospitals will be able to "make up the difference" by commanding premium prices in the delivery system based on their service offerings and reputations.

While the total of these set-aside funds would exceed current Medicare spending for direct graduate medical education costs and the indirect medical education (IME) adjustment, this premise indicates an apparent misunderstanding of the current competitive environment and the level of support that the academic mission requires. The Medicare program supports only a portion of the academic mission. Data from hospitals belonging to the AAMC's Council of Teaching Hospitals show that Medicare payments cover only about 20 to 33 percent of the costs associated with the academic mission. The other 67 to 80 percent must be obtained from public and private payers who provide the balance of funding for these additional costs pri-

marily through increased charges for services.

Historically, teaching hospitals have financed their multiple functions through cross subsidization. For example, patient service revenues have supported graduate medical education and other academic activities; routine service revenues have supported tertiary care patients; revenues from high volume services have supported low volume services; and payments from paying patients have supported charity care patients. However, during the past few years, as the overall costs of medical care have risen sharply, private health care payers have adopted payment systems—such as capitation, aggressive contracting and discounting—that restrict their payments to cover only goods and services they believe are necessary and of identifiable benefit to their enrollees. Costs associated with the education and research missions of teaching hospitals generally are not recognized by these payers.

in the newly price competitive environment, there is pressure to identify the cross-subsidized products of teaching hospitals. The AAMC believes that teaching hospitals will no longer be able to "make up the shortfall" to fund the costs associated with their academic missions through higher charges to patients. Therefore, the overall financing of the two funds must be adequate to ensure the continued financial viability of these institutions.

Notwithstanding these comments on the overall adequacy of the two provisions, the AAMC has several specific comments about the financing of the workforce and academic health center (AHC) accounts and about the need to address some tech-

nical issues.

The Health Security Act: Financing of the Health Professions Workforce Account

Summary. Payments for operating a residency training program and transitional payments to institutions that lose residency positions would be made from a federal health professions workforce account. The account would be funded at \$3.2 billion in Calendar Year (CY) 1996, the first-year of implementation; \$3.55 billion in CY 1997; \$4.8 billion in CY 1998; and \$5.8 billion in CY 1999 and CY 2000. In subsequent years, that amount would be increased by the general health care inflation factor. Medicare payments for the direct costs of graduate medical education would terminate for cost report periods beginning on or after October 1, 1995. Beginning in Federal FY 1996, Medicare would contribute to the workforce account: \$1.5 billion in FY 1996; \$1.6 billion in FY 1997 and FY 1998; and after 1998 the \$1.6 billion would be increased by the consumer price index. According to the administration's December 1993 analysis of the HSA: after the level of Medicare payments is determined, corporate and regional alliances pay the balance needed in the annual health professions workforce account, with such payments coming from the 1 percent corporate alliance assessment (under section 7121) and the 1.5 percent regional alliance payments are available for the annual health professions workforce account, with the remainder made available from payments by corporate alliances. In subsequent years, payments into the annual health professions workforce account are made in proportion to the total payments to corporate and regional health plans by corporate and regional alliances, respectively (Page 112).

Workforce payments in any year would be pro-rated if necessary on the basis of available funds. Starting in CY 1996, training programs that have applied and have been approved for payments would receive them directly from the Secretary of the DHHS. Calendar years 1996 and 1997 would be transitional years during which some states would not participate in the HSA. All states would be participants by CY 1998. In 1996 and 1997, the Secretary would first make payments to those programs located in participating states. Programs in non-participating states would receive pro-rated payments from the remaining funds in the workforce account.

Training programs would have to apply and be approved for payment and then would receive funds directly. Programs would submit applications to the Secretary of the DHHS for approval. Programs must agree to spend workforce funds only for the purpose of physician training. The institution within which the program operates would be required to agree that payments would be made directly to the pro-

gram by the Secretary.

Payments would be calculated using the national average cost for training residents multiplied by the number of full-time equivalent residents in the program. The national average cost would be determined using the 1992-93 academic year, trended forward by the consumer price index (CPI) for each year, and adjusted to reflect regional differences in wages and wage-related costs. The national average cost of training would consider the national average salary of residents and the national average salary of residents and the national average salary of residents.

tional average cost of providing faculty supervision and related activities.

Beginning in CY 1997, "transitional payments" to assist institutions that lose residency positions would be made from the health professions workforce account, subject to the availability of funds. The payment would be determined by multiplying the aggregate number of full-time equivalent positions lost by the national average salary of residents in 1992-93, updated by the CPI and adjusted for regional variation. The payment would be available for a four-year period, starting in the year in which an institution has fewer positions than during the 1993-94 academic year. Institutions may apply only once to receive the funds. For the first-year in which an institution would be eligible, the payment would be 100 percent of the national average salary, and would be reduced by 25 percent in each of the three subsequent years.

AAMC Comments on Workforce Financing

The AAMC has adopted the position that all payer financing of graduate medical education must accompany the establishment of a regulatory process for allocating residency positions if a national commission determines that market forces have failed to shift the balance of generalists and specialists. Upon creation of an all-payer fund for the costs of graduate medical education, the national commission would determine whether the medical education community has made adequate progress toward achieving its goals. If adequate progress has been made, there would be no need for the national commission to control the allocation of positions through a regulatory process, but a mechanism for distributing payments from the all payer fund would still be needed. However, if adequate progress has not been made upon establishment of the all payer fund, the commission could assume responsibility for authorizing payments for the costs of GME, and could develop and implement strategies to assure that the national goals are achieved.

implement strategies to assure that the national goals are achieved.

The AAMC is concerned that the amount of money in the workforce account is not adequate. This account does not include financing for the 8,500 residency positions which are currently funded by the Department of Veterans Affairs. It also appears to exclude payments for podiatry, oral surgery or general dentistry residents, for whom the Medicare program currently pays its proportionate share. In addition, the dynamics of how the regional and corporate alliances would participate in financing these costs are not well understood, including how these entities contribute

to both the workforce and the AHC accounts and at what level.

Even more troubling is that the overall level of the fund—\$5.8 billion in CY 2000 (which has not been adjusted for inflation to the year 2000)—is determined using a national average per resident amount which includes no overhead costs. It is our understanding that the aggregate funding needed for this account was estimated using only the national average resident's stipend and fringe benefits and an aver-

age salary and fringe benefit amount for faculty supervision.

The AAMC believes the level of payment should recognize all types of costs, including direct overhead costs, such as malpractice costs, classroom space and clerical support, and is concerned about the adequacy of the proposed national average payment which excludes overhead costs. The AAMC also is concerned about the use of a national average payment methodology and its redistributional effect across institutions. The overall financing of teaching hospitals and medical schools often is driven by historic circumstances, which have led to certain costs, especially faculty costs, being borne by the medical school, or in some cases, the teaching hospital. The diversity of faculty costs is probably the most important reason for the variation in Medicare per resident payments. Additionally, there are legitimate differences in educational models depending on the specialty and the institution. Residency programs also may have unique histories and differences in the funding available to them, such as state or local government appropriations. While the HSA requires the national average payment to be adjusted to reflect regional differences in wages and wage-related costs, these other structural factors would not be reflected in the HSA's proposed national average payment methodology, creating winners and losers inappropriately.

At its January 20, 1994 meeting, the Prospective Payment Assessment Commission (ProPAC) discussed recommendations on graduate medical education financing for its March 1994 report. Commissioners reviewed a staff analysis of graduate medical education costs and payments and noted the complexity of the distribution of these payments to hospitals. Chairman Stuart H. Aitmi, Ph.D., cautioned those who prefer moving to a national average payment methodology for residency costs without incorporating a number of adjustments in the payment system. Pointing to the commission's eleven-year experience with the prospective payment system—the first attempt by the federal government to standardize payments based on national averages—Dr. Altman noted how many adjustments had been added to the PPS over the years to achieve payment equity. ProPAC's preliminary analysis of graduate medical education costs found significant positive relationships between per resident costs and hospital size; its share of full-time equivalent residents in the outpatient setting; its share of costs related to faculty physicians' salaries; geographic region;

location in a metropolitan statistical area; and area wages.

The AAMC believes that since the HSA imposes an overall limit on the amount available for workforce funding, other payment policy options, which would distribute the funds more equitably among training sites, should be explored. The AAMC intends to pursue the development of alternative payment proposals that would recognize the significant diversity across institutions that participate in graduate medical education. We would be pleased to share our payment policy proposals with members of the committee and with the administration.

The AAMC believes that some institutions may be unduly harmed financially during the transition years of 1996 and 1997, when some states would not yet be participating in the HSA and would therefore receive pro-rated payments from the balance in the workforce account. It would be possible for the entity to receive a smaller payment in 1997 than it did in 1996. The AAMC believes that language should be added to the bill so that training entities would not receive less than they did in 1996, or less than they would have received from the Medicare program.

The AAMC understands that there is an error in the bill regarding the funding level of the workforce account in CY 1998. At \$4.8 billion, it is funded at \$1 billion less than it should be funded. CY 1998 would be the first-year in which all states would participate in the new system. Thus, a fully-funded workforce account of \$5.8 billion in CY 1998, and updated for inflation in CY 1999, would be essential.

Another correction needs to reflect the transition between the end of Medicare payments for direct graduate medical education costs and when payments from the workforce account would begin. As currently written, Medicare payments for these costs would terminate for cost reporting periods beginning on or after October 1, 1995. There may be a gap in available funding depending on the timing of the contributions.

The AAMC does not support payments being awarded directly to training programs. The association believes that payments from the workforce account should be made to the entity that incurs the cost. Recipients of payments could be teaching hospitals- medical schools, multi-specialty group practices or organizations that incur training costs. The AAMC strongly encourages the formation of formal associations, or graduate medical education consortia, to assure the continuity and coordination of medical education and to serve potentially as the fiscal intermediary in

distributing payments across various training sites.

The AAMC agrees that transition payments should be available to institutions that lose residency positions. However, the association is concerned about their timing and their adequacy. To encourage institutions to adjust the size and mix of their training programs, transition funds should be made available as soon aS the national council is operative. The HSA now states that these payments would not be available until CY 1997. Additionally, there should be some flexibility in how these payments are used so that institutions could try different approaches. The AAMC also is concerned that because an institution could apply only one time to receive payments, it would be locked into a four-year period during which it could become even more disadvantaged if further reductions in positions were imposed after the institution's application. Additionally, because these payments would be determined using only the national average salary of a resident, they will not provide enough relief. Some hospitals may still be unable to attract highly skilled non-physician practitioners or community physicians as substitutes for residents, particularly in inner city areas. Further, highly skilled non-physician practitioners are paid more than residents and will require physician supervision. These additional costs are not included in the transition payment amount. If a hospital replaces residents with non-physician practitioners, the salaries and supervisory costs of these non-physician professionals become permanent costs to the institution.

We support the funding for other health professionals-nursing and allied healththrough the continuation of Medicare hospital payments and through other authorized programs. How the costs of training general dentists, oral surgeons and podiatrists are paid under the HSA's plan is not clear. Currently the Medicare program pays their costs through the physician per resident payment amount. We believe the HSA language should be clarified as to how these trainees are funded.

The Health Security Act: The Academic Halt Center Account

Summary of the Act. The HSA would require the federal government to make payments to academic health centers and teaching hospitals to "assist eligible institutions with costs that are not routinely incurred by other entities in providing health services, but are incurred . . . by virtue of the academic nature of such institutions.

The HSA defines an "academic health center" as an entity that operates a school of medicine or osteopathic medicine; operates or is affiliated with one or more other health professional training schools or programs; and operates or is affiliated with one or more teaching hospitals. A "teaching hospital" is a hospital that operates an approved physician training program. To be "eligible" for payments from this account, institutions must apply each year to the Secretary of the DHHS and be "qualified" AHCs or "qualified" teaching hospitals. A "qualified" AHC operates a teaching hospital; a "qualified" teaching hospital is any teaching hospital other than one operated by an AHC. Payments could be in the form of a grant, contract or a cooperative agreement.

Total available amounts for payments would be \$3.1 billion in CY 1996; \$3.2 billion in each of CYs 1997 and 1998; \$3.7 billion in CY 1999; and \$3.8 billion in CY 2000, after which that amount would be updated by the general health care inflation factor in each subsequent year. As in the workforce account, AHC funds would be derived from three sources: Medicare, regional and corporate alliances. On October 1, 1995, Medicare indirect medical education payments under the prospective payment system would terminate and the program would contribute \$2.1 billion to the AHC account. In each of Federal Fiscal Years 1997 and 1998 the Medicare program would transfer \$2.0 billion to the AHC account, and in each subsequent year that amount would be increased by the CPI for all urban consumers and transferred to the account. As in the workforce account, regional and corporate alliances would make up the balance in the annual AHC account. For CYs 1996 and 1997, one-half of the 1.5 percent regional alliance assessment would be available with the remainder to be made available from payments by corporate alliances. The alliance contribution would increase based on the proportion of the population assumed to be in the new system.

Funds would be distributed among AHCs and teaching hospitals in proportion to the product of the institution's annual gross receipts for inpatient and outpatient care and the indirect teaching adjustment factor applicable to patients discharged from the center in the preceding year or in CY 1997. No later than July 1, 1996, the Secretary must submit a report to Congress with recommendations for modifying the allocation policies to eligible institutions. In making recommendations, the

Secretary is to consider the costs incurred by eligible institutions.

AAMC Comments on AHC Financing and Technical Issues

While the AAMC is pleased that the HSA would crate a separate fund for the costs associated with the academic mission, the legislative language in the bill causes confusion regarding the purpose of the funds and creates expectations that are not forthcoming in terms of which entity gets the payment. Much of the confusion arises from comparing this fund and its rationale with the indirect medical education (IME) adjustment and its purpose in the Medicare prospective payment system. The confusion is only compounded because the Medicare program eliminates the IME adjustment beginning in Federal FY 1996 and then contributes funds to the academic health center account. However, the purpose of the academic health center account—reduced productivity of faculty, uncompensated costs of clinical research and exceptional costs of specialized treatment—differs from the broad rationals behind the Medicare IMF adjustment for inaction ale behind the Medicare IME adjustment for inpatient hospital costs:

This adjustment is provided in light of doubts . . . about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents . . . the adjustment for indirect medical education is only a proxy to account for a number of factors which may legitimately increase costs a teaching hospitals (House Ways and Means Committee Report, Number 98-25, March 4, 1983. Senate Finance Committee Report, Number 98-23, March 11, 1983).

The AAMC suggests that the complete range of purposes of the AHC fund as described in the bill, which we assume to be examples rather than definitions of academic costs, along with the spectrum of costs associated with the academic mission, should be studied and incorporated in the Secretary's report to Congress. The AAMC believes that the due date as specified in the HSA, July 1, 1996, is too early, given the ambitious nature of the study, and should be changed to July 1, 1998.

A second point of confusion surrounds the definitions in the bill and the issue of what entity receives the AHC payment. Some definitions, such as the use of the term "operates," need further clarification. As stated in the bill, hospitals must "operate" training programs to receive payments from this account, but hospitals that participate in alliliated programs assumedly would not receive payments. There is no definition of "affiliated with" in the bill.

The AAMC has major concern that the AHC pool is seriously underfunded at \$3.8 billion (unadjusted for inflation) in the year 2000. While the intent of this fund is to provide assistance to academic health centers and teaching hospitals in "leveling the playing field" so that they may compete on a price basis with non-teaching providers, the size of the fund is insufficient to narrow the gap to a level where teaching hospitals and teaching physicians could expect to compete reasonably. Teaching physicians and hospitals recognize that, like all other providers, they will need to become more efficient in a competitive delivery system. However, an analysis of hospitals' costs per case in the eighth-year of the Medicare PPS (1991), conducted for the AAMC by Lewin-VHI, Inc., showed teaching hospitals on averagewere 32 percent more costly (excluding direct graduate medical education costs) relative to non-teaching hospitals. Lewin-VHI estimated that a level playing field between teaching and non-teaching hospital inpatient costs per case would have required funding from all payers of \$7.0 to \$8.3 billion in 1991, depending on the regression model used in the analysis.

However, the HSA requires payments to be calculated using inpatient and outpatient "gross receipts." Preliminary results from Lewin-VHI's analysis showed that an all-payer fund for the inpatient and outpatient costs of teaching hospitals would have had to be funded at \$9.0 to \$10.6 billion in 1991, significantly more than the \$3.8 billion planned for CY 2000, to address adequately the costs associated with the academic mission. The AAMC would be pleased to share the results of this analysis with the members of this analysis. ysis with the members of this subcommittee as the models and data are refined.

The AAMC has serious concern that the Medicare contribution to the AHC account would be lower than statistical analysis of the differences in inpatient hospital costs warrants. The HSA would reduce substantially the current IME payment formula to a rate of about 3.0 percent for every 0.1 percent increase in a hospital's intern and resident-to-bed ratio (IRB) beginning October 1, 1995, when the program would contribute \$2 billion to the AHC fund. Current Medicare IME payments are expected to be about \$4.2 billion in Federal FY 1994. The AAMC is unaware of any analysis that justifies the proposed level of reduction in the operating cost IME adjustment. The association views the proposed reduction in the IME adjustment as simply a mechanism for lowering Medicare's contribution to the AHC fund.

The AAMC also is concerned about using the Medicare resident-to-bed formula to allocate the fixed amount of money on a pro-rated basis to eligible institutions, which in effect pays institutions at a lower rate than 3 percent. Analysis presented by ProPAC staff at the commission's January 20 meeting found the distribution of AHC funds using the Medicare IME formula on a proportional basis to the maxi-

mum allowed by the bill resulted in an IME adjustment of 1.4 percent.

The AAMC is very concerned about the elimination of the IME adjustment as of October 1, 1995. These Medicare funds, which are essential to assuring that Medicare beneficiaries and others have access to services provided by teaching hospitals, would be reduced and removed from the PPS and then redistributed without knowing the impact on teaching hospitals' financial status. The AAMC urges the Congress to reflect carefully on this consequence when considering any change in the level of the IME adjustment, particularly until a new system is fully operational and the effect of the new system on the financial viability of teaching hospitals can be

The AAMC believes that the methodology of using the IRB to distribute AHC dollars unfairly penalizes a teaching hospital that is exempt for the prospective payment system. Presumably its IRB is zero. One remedy to this oversight may be to

calculate IRBs for these hospitals as if they were subject to the PPS.

Medical School Financing in an Era of Health Care Reform

Notwithstanding our specific comments on the workforce and AHC proposals, there is another issue of major concern to the academic community about which pollcy makers should be aware. Managed competition, the fundamental premise on which the HSA is based, would unravel medical schools' entire financing system of cross-subsidization, but would make accommodation for only a portion of the system by replacing it with two funds. The Health Security Act recognizes only academic costs that are already paid in the Medicare payment system, but fails to address the financial cross-subsidies of medical schools by offering no substitution for lost funds. The AAMC is concerned about the ability of medical schools to continue to support physician education, particularly at a time when medical schools and teaching physicians are being called on to transform the medical education system from one that focuses on specialist training in hospital inpatient settings to a more expensive system of generalist training in ambulatory, non-hospital sites.

Like teaching hospitals, medical schools, to a significant degree, finance edu-

cational and research activities through a complex system of cross-subsidization. Education, research and patient care exist as joint products. Undergraduate medical education is supported partially and directly by tuition and fees and state appropriations (primarily at public institutions). Table 2 on the following page shows that these sources of support accounted for 4.1 percent and 11.5 percent, respectively, of

total medical school revenues in 1991-92.

Research is supported partly by federal and local grants and contracts. Philanthropic support supplements these sources, but by themselves these funds remain insufficient. The current educational and research output of the nation's medical schools relies on significant revenues from the delivery of medical services by the faculty of the school. Revenue from the clinical faculty practice plan constituted 32.4 percent of total medical school revenue in 1991-92; in 1980-81, medical service revenue contributed only 15.7 percent of the total. Hospitals also support medical schools for activities conducted in the hospital. Reimbursements from hospitals have increased from 6.2 percent in 1980-81 to 11.4 percent in 1991-1992. Grants and contracts for medical services represented about 3.3 percent of total medical school revenue in 1991-92. Education also benefits from an elaborate system of nonpaid voluntary faculty drawn from the community.

For several reasons, medical schools will have difficulty sustaining this elaborate system undergirding the education and research missions. Federal support is increasingly constrained, with medical schools expected to accept a greater share of the costs. Pressures brought to bear on medical service costs will likely lead to declining income from the faculty clinical practice, and less money available to support educational and research efforts. In order to preserve the patient base critical for medical education and research, faculty physicians are being drawn into developing networks with affiliated teaching hospitals and are being asked to accept capitated or discounted payments from private payers. As community physicians are forced to align with various health plans in integrated networks, their willingness to "contribute" teaching services may even be threatened.

Undergraduate medical education in the clinical setting, directed by the medical school, is not recognized explicitly by any payment system, but like other academic costs, it has been financed indirectly. The shift to a more explicit financing system threatens the ability of medical schools and teaching hospitals to fund this activity through other sources of support. Funds from physicians' clinical incomes cannot be expected maintain their current levels. Fundamental forces are causing the traditionally cross-subsidized products to rise to the surface, yet only in two arenas has the HSA provided assistance. The AAMC believes that a complete and adequate financing system for academic medicine must be provided and we would be pleased to work with Members of Congress and the administration to remedy the situation.

#### CONCLUSION

Society must understand that supporting academic medicine ensures its vital role as an international leader in education, research and patient care. Medical schools and their faculties educate fully trained physicians to meet the nation's health care needs. Teaching hospitals provide an environment for the conduct of biomedical clinical research, serve as educational sites, and with their staff, work with academic physicians to deliver sophisticated patient care to all who need it. But academic institutions also need support to maintain their essential role in the health care system.

The AAMC is pleased that the HSA recognizes the important functions of these institutions. However, we must give considerable thought and attention to ensuring that these proposed changes, if enacted, would be implemented effectively and financed adequately. While we have some concerns about the two proposals, the AAMC shares in their overall objectives. We look forward to working with this sub-committee and the administration to ensure the future of academic medicine and the nation's health care system. We can afford to do no less.

[Additional material is retained in the files of the committee.]

Table 1 An Example of Adjusting Total First-Year Residency Training Positions: Reducing the Total Number to 110 Percent of 1992-93 Graduates While Maintaining a 55/45 Ratio of Generalists to Specialists

	Current (1992- 93) Filled First- Year Positions	-	1998-99	1999-2000	2000-01	2001-02	2002-03
Total	22,905		22,056	21,207	20,358	19,509	18,660***
Generalists*	7,817**		12,131	11,664	11,197	10,730	10,263
Specialists	15,088	-	9,925	9,543	9,161	8,329	8,397
LCME + Osteo Grads + 10%	18,662	-					

\*Generalists include residents in family medicine, general internal medicine, general pediatrics and obstetrics/gynecology.

\*\*AAMC estimate of PGY-1 trainees likely to complete training as generalists; proportion applied to current PGY-1 data based on experience of recent years, i.e, outcomes at the conclusion of residency training. \*\*\*18,660 total positions in 2002-03 used in this example as the target reflect the recommendations of the Council on Graduate Medical Education and the Physician Payment Review Commission that the total number of positions be reduced to 110 percent of graduates of LCME and AOA approved medical schools.

Source: Association of American Medical Colleges Tracking Survey, SAIMS Database, 1993.

TABLE 2 **REVENUES** U.S. MEDICAL SCHOOLS (DOLLARS IN MILLIONS)

	1980-81		1991-92	
Fully Accredited Schools Number of Schools Reporting	116 123		126 126	
GENERAL OPERATING REVENUES*	Amount	% of Total	Amount	% of Total
Federal Appropriations	57	0.9%	105	0.5%
State & Local Government Apropriations	1,351	20.8%	2,662	11.5%
Appropriations	1,252	19.3%	2,523	10.9%
Subsidies	99	1.5%	139	0.6%
Recovery of Indirect Cost Federal Government	445	6.9%	1,516	6.5%
State & Local Government	409	6.3%	1,309	5.7%
Non-Government	10 26	0.2%	32	0.1%
Medical Service Plans		0.4%	175	0.8%
	1,020	15.7%	7,505	32.4%
Tuition and Fees	348	5.4%	955	4.1%
Endowment (1)	110	1.7%	401	1.7%
Gifts (2)	46	0.7%	509	2.2%
Parent University Funds	113	1.7%	208	0.9%
Reimbursements from Hospitals	404	6.2%	2,640	11.4%
Miscellaneous Sources	172	2.7%	957	4.1%
Total General Operating Revenues*	4,066	62.7%	17,458	75.4%
GRANTS AND CONTRACTS				
Research	1,340	20.7%	3.705	16.0%
Federal Government	1,098	16.9%	2.787	12.0%
State & Local Government Non-Government	21	0.3%	101	0.4%
	221	3.4%	817	3.5%
Teaching & Training	397	6.1%	533	2.3%
Federal Government State & Local Government	277	4.3%	317	1.4%
Non-Government	35	0.5%	67	0.3%
Service & Multi-Purpose	85	1.3%	149	0.6%
Federal Government	491	7.6%	763	3.3%
State & Local Government	124 265	1.9%	181	0.8%
Non-Government	102	4.1%	362 220	1.6%
Research & Teaching/Training Programs		1.0 %	220	1.0%
at Affiliate Institutions	188	2.9%	688	3.0%
Total Grants and Contracts	2,416	37.3%	5,689	24.6%
TOTAL REVENUES	6,482	100.0%	23,147	100.0%

Includes unrestricted and restricted endowment (2) Includes one provisionally approved school

Detail may not add due to rounding.

SOURCE: LCME Questionnaire, Part I-A, Section for Operational Studies.

TABLE 3

NUMBER OF RESIDENTS AND FELLOWS
RANKED BY TOTAL TRAINEES BY SPECIALTY
1993

Specialty	No. of Residents	No. of Fellows	No. Physician in GME	% of Total	Cumulative %
Internal Medicine	19,962	10,581	30,543	30.9%	30.9%
Pediatrics	6,600	2,389	8,989	9.1%	40.0%
Surgery	7,832	886	8,718	8.8%	48.8%
Family Practice	6,925	539	7,464	7.6%	56.4%
Psychiatry	5,138	912	6,050	6.1%	62.5%
Anesthesiology	5,078	896	5,974	6.0%	68.6%
Obstetrics-Gynecology	4,665	620	5,285	5.3%	73.9%
Radiology	3,606	1,478	5,084	5.1%	79.0%
Orthopedic Surgery	2,752	583	3,335	3.4%	82.4%
Pathology	2,222	734	2,956	3.0%	85.4%
Emergency Medicine	2,024	354	2,378	2.4%	87.8%
Ophthalmology	1,476	332	1,808	1.8%	89.6%
Neurology	1,355	444	1,799	1.8%	91.5%
Transitional	1,589		1,589	1.6%	93.1%
Otolaryngology	819	403	1,222	1.2%	94.3%
Urology	911	246	1,157	1.2%	95.5%
Physical Medicine/Rehab.	993	118	1,111	1.1%	96.6%
Dermatology	708	261	969	1.0%	97.6%
Neurosurgery	630	224	854	0.9%	98.5%
Plastic Surgery	161	362	523	0.5%	99.0%
Thoracic Surgery		345	345	0.3%	99.3%
Preventive Medicine	235	57	292	0.3%	99.6%
Allergy/Immunology		169	169	0.2%	99.8%
Nuclear Medicine	90	45	135	0.1%	
Colon & Rectal Surgery		64	64	0.1%	100.0%
TOTAL	75,771	23,042	98,813	100.0%	

Source: Association of American Medical Colleges, Medical Education Cansus, SAIMS Database, 1993

TABLE 4

NUMBER OF FMGs IN GME

RANKED BY PERCENTAGE OF FMGs OF TOTAL TRAINEES BY SPECIALTY

1993

Specialty	No. of FMGs	No. Physician in GME	% of Total	% of Total FMGs
Nuclear Medicine	52	135	38.5%	0.2%
	10,402	30.543	34.1%	49.8%
Internal Medicine		,-	31.0%	13.3%
Pediatrics	2,787	8,989		
Allergy/Immunology	52	169	30.8%	0.2%
Neurology	526	1,799	29.2%	2.5%
Pathology	819	2,956	27.7%	3.9%
Psychiatry	1,534	6,050	25.4%	7.3%
Family Practice	1,396	7,464	18.7%	6.7%
Transitional	293	1,589	18.4%	1.4%
Colon & Rectal Surgery	11	64	17.2%	0.1%
Anesthesiology	862	5,974	14.4%	4.19
Preventive Medicine	36	292	12.3%	0.29
Physical Medicine/Rehab.	110	1,111	9.9%	0.59
Surgery	849	8,718	9.7%	4.19
Neurosurgery	83	854	9.7%	0.49
Thoracic Surgery	31	345	9.0%	0.19
Plastic Surgery	37	523	7.1%	0.29
Obstetrics-Gynecology	369	5,285	7.0%	1.89
Ophthalmology	107	1,808	5.9%	0.5%
Radiology	269	5,084	5.3%	1.3%
Urology	59	1,157	5.1%	0.39
Dermatology	43	969	4.4%	0.29
Emergency Medicine	101	2,378	4.2%	0.59
Otolaryngology	25	1,222	2.0%	0.19
Orthopedic Surgery	49	3,335	1.5%	0.29
TOTAL	20,902	98,813	21.2%	100.09

Source: Association of American Medical Colleges, Medical Education Census, SAIMS Database, 1993

TABLE 5
PHYSICIANS IN GME RANKED BY STATE, 1993

PHYSICIANS IN GME RANKED BY STATE, 1993					
State	No. Physician in GME	% of Total	Cumulative %		
New York	14,805	15.0%	15.0%		
California	9,004	9.1%	24.1%		
Pennsylvania	7,236	7.3%	31.4%		
Texas	5,859	5.9%	37.3%		
Illinois	5,530	5.6%	42.9%		
Ohio	4,728	4.8%	47.7%		
Massachusetts	4,433	4.5%	52.2%		
Michigan	3,904	4.0%	56.2%		
New Jersey	2,603	2.6%	58.8%		
Maryland	2,491	2.5%	61.3%		
Florida	2,413	2.4%	63.8%		
Missouri	2,233	2.3%	66.0%		
North Carolina	2,211	2.2%	68.3%		
Minnesota	2,193	2.2%	70.5%		
District of Columbia	2,179	2.2%	72.7%		
Connecticut	1,878	1.9%	74.6%		
Georgia	1,826	1.8%	76.4%		
Tennessee	1,798	1.8%	78.3%		
Virginia	1,751	1.8%	80.0%		
Wisconsin	1,583	1.6%	81.6%		
Louisiana	1,504	1.5%	83.1%		
Washington	1,415	1.4%	84.6%		
Indiana	1,162	1.2%	85.8%		
Colorado	1,130	1.1%	86.9%		
Alabama	1,002	1.0%	87.9%		
Arizona	997	1.0%	88.9%		
Kentucky	986	1.0%	89.9%		
South Carolina	908	0.9%	90.8%		
Inwa	846	0.9%	91.7%		
Puerto Rico	779	0.8%	92.5%		
	702	0.7%	93.2%		
Kansas	683	0.7%			
Oklahoma		0.7%	94.5%		
Oregon	548				
Rhode Island	576	0.6%	95.1%		
Utah	560	0.6%			
Arkansas	534	0.5%			
Nebraska	499	0.5%			
West Virginia	496	0.5%			
Mississippi	432	0.4%			
Hawaii	430	0.4%			
New Mexico	386 265	0.4%			
Vermont	238	0.3%			
New Hampshire Maine	214	0.2%			
Delaware	195	0.2%			
North Dakota	120	0.1%			
Nevada	112	0.1%			
South Dakota	85	0.1%			
Idaho	39	0.0%			
Wyoming	38	0.0%			
Montana	Ö	0.0%	99.8%		
Alaska	ō	0.0%	99.8%		
Unidentified Military	98,813	100.0%			

Source: Association of American Medical Colleges, Medical Education Consus, SAIMS Database, 1993

TABLE 6 PHYSICIANS IN GME PER THOUSAND POPULATION BY STATE, 1993

State	No. Physicians in GME	Population	Phys. in GME per 1,000 population
District of Columbia	2,179	589,000	3.70
New York	14,805	18,119,000	0.82
Massachusetts	4,433	5,998,000	0.74
Pennsylvania	7,236	12,009,000	0.60
Rhode Island	576	1,005,000	0.57
Connecticut	1,878	3,281,000	0.57
Maryland	2,491	4,908,000	0.51
Minnesota	2,193	4,480,000	0.49
llinois	5,530	11,631,000	0.48
/ermont	265	570,000	0.46
Aissouri	2,233	5,193,000	0.43
Ohio	4,728	11,016,000	0.43
Michigan	3,904	9,437,000	0.41
lawaii	430	1,160,000	0.37
ennessee	1,798	5,024,000	0.36
ouisiana	1,504	4,287,000	0.35
ew Jersey	2,603	7,789,000	0.33
exas	5,859	17,656,000	0.33
olorado	1,130	3,470,000	0.33
orth Carolina	2,211	6,843,000	0.32
/isconsin ebraska	1,583	5,007,000	0.32
eoraska tah	499	1,606,000	0.31
wa	560 846	1,813,000	0.31
alifornia	9,004	2,812,000	0.30
elaware	195	30,867,000	0.29
ansas	702	689,000	0.28
ashington	1,415	2,523,000	0.28
irginia	1,415	5,136,000	0.28
est Virginia	496	6,377,000	0.27
eorgia	1,826	1,812,000	0.27
entucky	986	6,751,000	0.27
rizona		3,755,000	0.26
outh Carolina	997	3,832,000	0.26
ew Mexico	908	3,603,000	0.25
abama	386	1,581,000	0.24
	1,002	4,136,000	0.24
kansas egon	534	2,399,000	0.22
egon w Hampshire	648	2,977,000	0.22
lahoma	238	1,111,000	0.21
diana diana	683	3,212,000	0.21
orth Dakota	1,162	5,662,000	0.21
erida	120	636,000	0.19
aine	2,413	13,488,000	0.18
ssissippi	214	1,235,000	0.17
ssissippi uth Dakota	432	2,614,000	0.17
vada	85	711,000	0.12
vada roming	112	1,327,000	0 08
/oming	38	466,000	0.08
ntana	39	1,067,000	0.04
aska	0	824,000	0
erto Rico	0	568,000	0
	779	~	**
identified Military	98,813 Z		

Source: Association of American Medical Colleges, Medical Education Census, SAIMS Database, 1993 Population Data: U.S. Bureau of the Census, Current Population Reports, 1992

TABLE 7
FMGs IN GME, RANKED BY % OF PHYSICIANS IN GME BY STATE, 1993

	No. Physicians in GME			% of Total
State		No. of FMGs	% FMGs of	FMGs in U.S.
lew Jersey	2,603	1,377	52.9%	6.6%
Vorth Dakota	120	50	41.7%	0.2%
lew York	14,805	6,168	41.7%	29.5%
Vevada	112	40	35.7%	0.2%
Puerto Rico	779	269	34.5%	1.3%
llinois	5,530	1,797	32.5%	8.6%
Michigan	3,904	1,154	29.6%	5.5%
Connecticut	1,878	549	29.2%	2.6%
West Virginia	496	121	24.4%	0.6%
Rhode Island	576	123	21.4%	0.6%
	7,236	1,419	19.6%	6.8%
ennsylvania		306	19.3%	1.5%
Wisconsin	1,583	479	19.3%	2.39
Maryland	2,491			
Dhio	4,728	908	19.2%	4.39
District of Columbia	2,179	411	18.9%	2.09
Florida	2,413	417	17.3%	2:09
Missouri	2,233	367	16.4%	1.89
Massachusetts	4,433	722	16.3%	3.59
Oklahoma	683	107	15.7%	0.59
Tennessee	1.798	275	15.3%	1.39
Vinnesota	2.193	323	14.7%	1.59
Texas	5,859	845	14.4%	4.09
South Dakota	85	11	12.9%	0.19
Georgia	1,826	222	12.2%	1.19
ndiana	1,162	139	12.0%	0.79
Centucky	986	113	11.5%	0.59
Virginia	1.751	185	10.6%	0.99
California	9.004	943	10.5%	4.5
	846	81	9.6%	0.49
lowa		25	9.4%	0.19
Vermont	265	47	9.4%	0.2
Nebraska	499	20	9.4%	0.1
Maine	214		9.3%	0.1
Delaware	195	18 91	9.2%	0.1
Alabama	1,002 702	63	9.0%	0.3
Kansas	534	45	8.4%	0.2
Arkansas	997	77	7.7%	0.4
Arizona	430	33	7.7%	0.2
Hawaii	432	31	7.2%	0.1
Mississippi	908	63	6.9%	0.3
South Carolina	2.211	152	6.9%	0.7
North Carolina	1.504	95	6.3%	0.7
Louisiana Utah	560	32	5.7%	0.2
New Mexico	386	20	5.2%	0.1
ldaho	39	2	5.1%	0.0
Colorado	1,130	57	5.0%	0.3
New Hampshire	238	12	5.0%	0.1
New Hampshire Oregon	648	30	4.6%	0.1
Washington	1.415	65	4.6%	0.3
wasnington Wyoming	38	1	2.6%	0.0
Montana	0	Ö	2.070	0.0
			-	
Alaska	0	Ö		0.0
Unidentified Military	174	2	1.1%	0.0

Source: Association of American Medical Colleges, Medical Education Census, SAIMS Database, 1993

## PREPARED STATEMENT OF DR. JOHN NAUGHTON

#### INTRODUCTION

I appreciate this opportunity to spend a few minutes discussing the promise of consortial governance of graduate medical education. My remarks will be directed toward the experiences we have had in Buffalo, New York since 1983 and how these relate to the directions recommended by the Council on Graduate Medical Education (COGME).

## THE PROBLEM

The United States undoubtedly has the best medical education and health care in the world. Since World War Two the number of medical schools increased from 87 to 125; the number of graduates increased from 7500 to over 16,000 annually; and a well organized specialty training system was developed. The nation's medical schools and teaching hospitals have synthesized a fantastic enterprise often referred to as academic medical or academic health centers. In this framework medical and health science education, biomedical research and patient care are integrated to provide the excellence that the country has achieved in health care. While these advances occurred many unmet needs developed. For example, the relationship of specialists to generallsts was significantly distorted; care for the urban and rural system was substantially reduced; costs for health care consistently escalated beyond the usual rate of inflation; and physicians and medical schools became too hospital dependent ignoring the broader areas of community health and continuity of ambulatory care.

Today, the nation finds itself at the threshold of the challenging task to reform its health care system. It is apparent that health care reform will necessitate educational reform, and thus the academic health structure must be just as involved as the health care delivery system in shaping the future.

## FOCUS ON GRADUATE MEDICAL EDUCATION

It is apparent that while medical schools must modify their curriculum to prepare properly more graduates to enter primary or generalist careers, that the real emphasis for change must be directed toward graduate medical education (GME). This is so because GME has become the system which prepares the graduates for their specialty. Given the reality that at least two-thirds of medical school graduates enter technological specialties, the distribution of training positions must be altered if more generalists are to enter practice. This will be no easy feat!

New York State Government recognized this problem in the early 1980's, and Governor Mario Cuomo appointed a Commission on Graduate Medical Education. That Commission confirmed the seriousness of the GME mission for NYS and its twelve medical schools, four public and eight private. NYS trains 1/6 of all GME positions in the United States, yet is populated by only 1/12 of the nation's citizens. Despite these large numbers, NYS has an inverse proportion of generalists to specialists, and is beset by the identical geographical maldistribution that exists throughout the country. And, just as is the situation in other states and regions, there are too few physicians from minority, socially disadvantaged and socially underrepresented constituencies.

The Commission made a number of recommendations designed to address these problems and the NYS Legislature established the Council on Graduate Medical Education in 1987. Both the Commission and the Council recommended that GME be coordinated by the twelve medical schools together with their networks of affiliated teaching hospitals. One model recommended for governing GME was the formation of consortia, and the model in Buffalo was suggested as one possibility.

# THE GRADUATE MEDICAL DENTAL EDUCATION CONSORTIUM IN BUFFALO

The concept of consortial governance for GME in Buffalo, New York antedated the formation of Governor Cuomo's Commission. Its roots were initiated in 1982 and it began operation in 1983. Its formation was stimulated by the new guidelines of the Accreditation Council on GME (ACGME) which mandated that these programs be governed by an institution of record. The schools of Medicine and Dental Medicine at the State University of New York at Buffalo and the leadership of the eight teaching hospitals recognized that a single institution was desirable. Thus, the Graduate Medical Dental Education of Buffalo (the Consortium) became the institution of record for the ACGME, and the two schools and eight teaching hospitals (today, nine), are the participating Institutions. This consortium governs all residency training programs in the eight countles of Western New York, whether University supervised or free standing.

## CONSORTIUMS IMPACT ON GME REFORM

The Consortium developed a Demonstration Project in 1989-90 designed to respond to several of the problems identified by the NYS Council on GME and recently enumerated by COGME. These included:

A. Governance - The ten year experience of the Consortium indicates that governance need not be complicated. The organization represents an example of shared cooperative governance in which each participating institution has one vote. The committee structure is composed of an Administrative Committee which acts as the Executive body, the Program Directors Committee, and the Residents Committee. There is cross representation from each committee designed to enhance communication. The Dean of the medical school serves as the Chairman. It is important to emphasize that all program directors participate in this important committee.

All Residency Review Applications are reviewed by the Program

Directors Committee and approved by the Administrative Committee prior
to submission to the ACGME.

- B. Participation by Payors A Demonstration Project has been funded by the non-Medicare payors in WNY. Approximately 2/3's of the funds have come from the region's major private payors, Blue Cross-Blue Shield, Health Care Plan and Independent Health Association, and 1/3 from the Department of Social Services (Medicaid). The projects' contract is between the Consortium and its participating institutions, these payors and the New York State Department of Health. This project has facilitated an ongoing relationship between the Consortium and the payors who contribute actively to new directions that the Consortium will pursue.
- C. Sharing and Pooling of Funds Since its inception each participating institution has provided a range of in-kind services and has shared in the costs of many projects. In the current Demonstration Project, two major "pooling" efforts were undertaken.
  - a. Resident Salaries The participating institutions agreed to pool the direct medical and dental education funds necessary to pay the direct stipends and fringe benefits. Appropriate not-for-profit corporate structures were established for employing the residents. The change resulted in all residents being paid a comparable salary and fringe benefit rate regardless of the institution which contributed to the pool. It resulted in an improved fringe benefit package at a lower cost to one institution and only a minimum increase to the others. Today, the direct funds used to pay residents are evaluated annually by the participating institutions Chief Financial Officers. The decision on salary and fringe benefit adjustments is determined by the trend factor which NYS applies to the GME base. This increase is used to negotiate

salary and fringe benefits increases and adjustments with the residents

- b. Indirect Medical Education Funds Since January 1, 1992, the participating hospitals have pooled a portion of the non-Medicare Indirect Medical Education Funds (IME) to seed projects designed to achieve major changes in the GME programs. The pool in 1992 approximated 5 percent of the IME received; In 1993, 10 percent; and in 1994, 20 percent. The aggregate funds pooled over the three year period will approximate 5.1 million dollars. The expenditure of these funds requires the approval of the Consortium's Administrative Committee. (These funds are used to support the various program initiatives that are reviewed later in this document).
- <u>D.</u> Programmatic Changes Since 1991, the Consortium has advanced the following goals:
  - 1. Primary Care It agreed to achieve a distribution of 50 percent of its placements to the Primary Care or Generalist Specialties by 1995. The total GME pool for WNY is 788 positions, an allocation which approximates 25 per 100,000 residents of WNY. The base against which the 50 percent allocation will access is 750. At the present time, 42 percent of the Consortium GME positions are allocated to the Primary Care Specialties. We are confident that this pool will be filled after the 1994 match program is completed. If that plateau is reached, then an 8 percent shift of positions from those currently assigned to the remaining training programs must occur.
  - 2. Capping the GME Pool The Consortium agreed to cap the total resident pool at 788. This decision obviously has the effect of

terminating the previously erratic and uncontrolled escalation of costs for GME in the region. In the future any program expansion on new program development must be approved by all of the participants in the project.

- 3. Minority Recruitment and Retention The Consortium is committed to recruit and retain a minimum of minority and socially disadvantaged residents of 11 percent. UB's medical school has been a major participant in preparing medical students from minority and socially disadvantaged populations. Today, the GME pool is comprised of a 9.5 percent representation of these constituents.
- 4. Geriatrics and Chronic Care NYS and WNY have a higher proportion of citizens aged 65 years and older. Their distribution in WNY approaches 17 percent. Thus, the Consortium made a commitment to strengthen and enlarge its programs in geriatrics. At the same time, the Consortium relates to the only Children's Hospital in Upstate New York and to two state operated institutions, the West Seneca Development Center and the school for Hearing Impaired in Batavia, New York. These institutions serve to provide training to medical students and residents in the area of chronic childhood disabilities which must be tended to in adult life.
- 5. IME Upweighting The NYS Council on GME instituted an upweighting of IME funds favoring the primary care specialties. Currently, teaching hospitals are reimbursed on criteria established for primary care programs. The specialty training programs are reimbursed at the rate of 0.9 and the primary care programs at 1.5. This approach has proved a valuable incentive to the Consortium to advocate changes in its GME programs designed to accelerate

the rate at which the 50 percent commitment to primary care residents can be met.

E. Advantages of Consortia - The Consortium and NYS recognized that this effort was somewhat rudimentary, untested, and unproved. Thus, the Demonstration Project is designed to test and evaluate whether shared, community governance led by a medical school can achieve significant changes at reasonable costs. The Consortium began as a local initiative, and has voluntarily accepted the authority and responsibility of the NYS Council on GME to evaluate its performance. At least two site visits have been conducted by the Council's Sub-Committee on Consortia, and to date we have met the criteria established by the Council which define the requirements to perform as a Consortium. The concept of an overall central authority which will guide the allocation of GME positions and the direction of consortia seems appropriate. However, the Buffalo Consortium feels strongly that the actual operation should be left to regions with such mechanisms. The Consortium's experience is that change is best facilitated by those most directly involved in the operation of the GME programs and the health needs of the community. We realize that since most consortia will not be able to support every specialty or subspecialty training program that cooperation among or between consortium may have to occur. In the WNY situation, we envision such collaborations occurring with our neighbors in Rochester and Syracuse at a minimum. Thus, while COGME's recommendation for a national body seems reasonable and appropriate, it probably should have policy making authority, but not operational and regulatory authority.

F. Additional Outcomes - Many positive changes have occurred as a result of consortial governance and the demonstration project. Four deserve particular emphasis:

- 1. The Primary Care Resource Center The Initial thrust of the IME pooling was to seek faculty projects designed to foster generalist initiatives. The initial effort culminated in the formation of a new unit, the Primary Care Resource Center (PCRC). This unit is supervised by the chairpersons of Family Medicine, Internal Medicine, Pediatrics and Social and Preventive Medicine. They serve to stimulate those activities long deemed necessary to make primary care education succeed and to coordinate rather than to duplicate the efforts of each program. The PCRC has been particularly effective, In a very short period of time, in conducting programs in teaching effectiveness, developing 12 model ambulatory education sites, and in enhancing recruitment and retention to the various primary care programs.
- 2. Medical School Education The positive climate established by the PCRC and the leadership of the primary care chairpersons has served to position the school to implement curricular changes in the medical school and to seek one of the 12 Generalist Initiative Awards to by funded by the Robert Wood Johnson Foundation. Already, the faculty have implemented a Family Medicine Clerkship in the third year which will begin in the Fall, 1994.
  - 3. Information System Everyone agrees that the primary care movement and health care reform will not succeed without a comprehensive Information System Network designed to transmit educational, clinical and organizational information. Although, in the rudimentary stages, the Consortium has served as a vehicle to initiate a regional information system which will eventually reach every physician and hospital in WNY.

4. Expanded Research Portfolio - The University at Buffalo Is numbered among the leading research universities in America and is a member of prestigious AAU. In 1989, the medical school faculty recommitted to being a viable, strong biomedical research unit while realizing that its portfolio and characteristics, like those of other medical schools, must be expanded if the challenges of the 21st Century are to be met. Thus, Consortium and medical schools must work to relate health services research and other public health service initiatives to the development of primary care faculty and to the education of medical students and residents.

## OTHER CONSIDERATIONS

Hopefully, most of the foregoing serves to Indicate that many of COGME's recommendations for Physician Workforce Reform are sound and reasonable.

There are other concerns raised by COGME that must be addressed and implemented.

A. Transitional Funding - The redirection of medical education and GME reform can be slow and painful. For many medical educators and researchers there will be a need to learn, understand and accept the social urgency to deal with educating excellently prepared generalists and fewer specialists and biomedical scientists. Only a few medical schools will be Immune from this drastic situation. The Congress and Administration and our society which has grown impatient and angry about some of the failures in providing cost effective continuity of care needs to assist us in these transitions both emotionally and fiscally, and participate whenever the opportunity comes to facilitate change and cooperation.

The health care system, particularly large teaching hospitals, are faced with the tremendous challenge of becoming less resident oriented and dependent. While this direction is necessary, there will be a tremendous burden on changing how hospital care and education is

conducted in these facilities. Medical schools and teaching hospitals must expand their relationships with other schools, particularly nursing schools, to educate more nurse practitioners, physician assistants and midwives to replace the faculty effort and residents who will perform more and more of their duties in ambulatory and community health settings.

Funds will be needed from the federal and state governments to provide the support and incentives necessary to accomplish the dreams embodied in health care reform.

B. Support of Students and Residents - The nation probably made a bad decision in the 1970's when medical school tuition in the private sector was allowed to float. We now enter an era when the cost of medical education could exceed a physician's ability to generate it adequately in his practice years, particularly if a generalist. Thus, Congress must enact legislation designed to relieve the debt burden for those well educated, well motivated men and women who will respond to the challenge to serve the urban poor, the deprived rural citizens, and to help overcome other unmet needs. To do so will require a new, well administered loan forgiveness and incentive programs.

#### CONCLUSION

It seems axiomatic that health care reform cannot succeed without health education reform and the active participation of the nation's academic health centers, especially its medical schools. The Fourth Annual COGME Report provides a solid rationale for the formation of GME Consortia and the directions in which educational reform should proceed to meet the nation's health workforce needs. Based on the experience of Buffalo's GME Consortium, we agree:

GME should be funded by all payors.

- Regional Consortia composed of a medical school and its affillated network of hospitals, program directors, payor representatives and possibly consumers offers one model for achieving the stated social goals for GME reform.
- The direct payment for GME should be contracted to consortia.

#### PREPARED STATEMENT OF ELI GINZBERG

- Our recent research shows 50-fold variation of physicians in private practice in affluent suburbs vs. inner city in nation's 4 largest metros: 1:3(X) vs. 1:15,000.
- Unless physicians are attracted to work in low-income areas it doesn't matter whether
  we increase the output of primary care MDs or not. To attract them we need better
  financial and professional incentives. These have been lacking since Congress passed NHSC
  in 1970.
- 3. We don't need as many specialists as we are currently training--ratio of more than 80 percent. But most Americans with good insurance get good care under this approach although the costs are higher than they should be. However, not easy to shift in short-term.
  Remember Congressional action in 1976--50 percent generalists. Had to be rescinded.
- If surplus of specialists as at present many take care of regular patients—cf.
   Mendenhall study of 1979--specialists provide about 20 percent primary care.
- 5. Many different ways of providing primary care. In rural areas feds let nurse practitioners run public clinics. In Mayo and Palo Alto clinics most of care provided by specialists with mid-level assistants like nurses. In NYC public hospitals most of care by residents pursuing specialized training.
- Federal government should not pay for GME beyond first certification.

- 7. Ebert, Ginzberg recommended in 1988 (*Health Affairs*) how 2 years could be saved out of 7 years to first certification. Slow progress along this line.
- 8. See recent exchange in New England Journal of Medicine re nurse practitioners.
- Must be careful in cutting back on GME etc. not to destabilize major AHCs such as
   6 in NYC.
- 10. At best it will take long time to shift ratio of generalists to specialists. Lots of other things need doing like more clinics-better pay for MDs serving poor, better professional support.

#### PREPARED STATEMENT OF DR. JACK COLWILL

Senator Kennedy, Senator Kassebaum and members of the Senate Committee on Labor and Human Resources:

I am Jack Colwill, M.D., Professor and Chairman of the Department of Family and Community Medicine at the University of Missouri-Columbia School of Medicine. I am a member of the Executive Committee of the federally authorized Council on Graduate Medical Education (COGME).

With this testimony, I am submitting for the record the Fourth Report of the Council on Graduate Medical Education. This report provides a legislative plan to achieve physician workforce goals in a predictable and timely fashion. It maximizes decision making at the local and private level under broad federal workforce mandates. Its goals are consistent with proposals introduced by the President and by the members of this committee.

The Council believes that successful health care reform must contain effective strategies to train more generalists and fewer specialist physicians. These strategies also should address methods to increase the number of minority physicians and to improve the geographic distribution of

physicians. I focus my remarks on those components of the report dealing with graduate medical education.

The current mismatch between physician supply and health care needs will be magnified as the nation establishes universal access to care and shifts to systems of managed care. The Bureau of Health Professions projects a year 2000 shortage of 35,000 generalist physicians and a surplus of 115,000 specialist physicians in a managed care dominated system if current patterns of specialty choice and numbers of graduates persist.

Given health care requirements, COGME adopted the following physicians workforce goals for the year 2000:

- At least 50% of residency graduates should enter practice as generalist physicians
   (family physicians, general internists, and general pediatricians).
- The physician to population ratio should be maintained at current levels.
- The number of under-represented minority students should be doubled.
- o Rural and inner city primary care shortage areas should be eliminated.

COGME believes that market forces created by a changing health care system will not correct these physician workforce deficiencies in the near future. The financial rewards for specialists in the marketplace, the specializing influence of medical education, and the needs of teaching hospitals for residents to provide service have been forces which have tended to maintain the status quo. Indeed, only 10 of 126 allopathic medical schools had over 35% of graduates between 1987 and 1989 enter generalist practice. The failure to train adequate numbers of generalists can only hinder efforts to expand access to health care and to develop effective systems of managed care.

Rather than providing open-ended funding of residency positions, COGME recommends that public funds utilized to support graduate medical education should be used to obtain the necessary number and specialty inix of physicians. Consequently, the Fourth Report presents legislative recommendations:

- providing funding of graduate medical education by all third party payers;
- assuring that 50% of residency graduates become generalists;
- limiting total funded positions to the number of U.S. medical school graduates in
   1993 plus ten percent;
- allocating the reduced number of GME positions to medical school coordinated consortia;
- providing transition payments to those teaching hospitals most effected by the loss
   of resident positions;
- expanding incentives to individuals and institutions through expanded funding of
  Title VII and National Health Service Corps to graduate more generalist and
  minority physicians, to improve the geographic distribution of physicians, and to
  build the primary care teaching capacity necessary for an expanded system of
  training generalists;
  - establishing a National Workforce Commission to recommend means of allocation
     of residency positions and to advise Congress and the Department of Health and
     Human Services (DHHS) on issues of physician workforce policy.

COGME believes that all third party payers should contribute to the funding of graduate medical education. While Medicare currently pays its pro rata share of the cost of graduate medical

education, the remainder of the direct costs are derived from other sources of patient care income. As academic medical centers increasingly compete for the care of managed care populations, it will be increasingly difficult for them to assume the direct costs of graduate medical education.

The centerpiece of COGME's proposal is the development of private sector consortia which would function as "accountable education partnerships" in the allocation of residency positions. These consortia would be composed of one or more medical schools, teaching hospitals, other institutions which train physicians, and representatives of the public. The Department of Health and Human Services would allocate an overall reduced number of residency positions to each consortium utilizing criteria developed by the National Physician Workforce Commission.

Each consortium, coordinated by one or more medical schools, would be mandated to increase generalist positions and to reduce specialty positions so that half of all trainees would become generalists. Decisions on allocation of residency positions would be made collectively by each consortium based on local, state, and regional health care needs as well as the quality of individual programs within the consortium. The consortium proposal does not attempt to define at the national level the exact number of residency positions that should be offered in each of the 81 specialties at each institution. COGME believes that this task would be extraordinarily difficult, would provide excessive micromanagement of the system, and should be accomplished at the local level.

The National Workforce Commission will monitor trends in workforce production and needs. It will recommend to Congress and the Secretary of DHHS ongoing modifications in workforce goals, provide guidelines for allocation of numbers of positions of each consortium, and provide recommendations for addressing shortages and surpluses in specific specialties. In order to carry out its mission, this National Workforce Commission must be adequately funded and staffed.

With implementation of these recommendations, the nation would produce 25% fewer physicians annually-of whom at least half would practice as generalists. The total number of first year

residency positions would be reduced from 24,000 to 19,000. Overall, residency positions in the non-generalist specialties would be reduced by approximately 45%.

The reduction in residency positions has potential to create difficulty for many of the nation's teaching hospitals. Resident physicians help meet service needs of teaching hospitals and because of GME reimbursement are of modest cost for the hospital. The net impact has been expansion of residency positions and a spiraling number of specialty-trained physicians entering the workforce. These hospitals have great needs. COGME believes that the graduate medical education payments saved by the overall reduction in residency positions should be redirected to assist those hospitals that are most effected by the reduced numbers. The proposed changes in numbers should also be phased in over several years. A portion of dollars saved should also be utilized to assist institutions in the development of an increased capacity to educate generalist physicians.

If Congress enacts COGME's recommendations, our educational institutions would approach the goal of increasing the proportion of generalist physician graduates to 50% and maintaining physician to population ratio. The consortium approach will maximize private sector input and creativity. Incentives for individuals and institutions will assist in the transition, helping new physicians and the medical education system respond to changing demands of the health care market. Our nation will produce a physician workforce that is closely matched to tomorrow's health care needs.

I wish to thank the committee for this opportunity to present the recommendations of the Council on Graduate Medical Education.

[Additional material is retained in committee files.]

#### PREPARED STATEMENT OF ANN ELDERKIN

#### Mr. Chairman and Members of the Committee:

The American Academy of Physician Assistants (AAPA), on behalf of itself and the Association of Physician Assistant Programs (APAP), is pleased to present our views on the workforce issues contained within the Clinton health proposal that you are now considering.

#### AAPA and APAP

The AAPA represents the 23,500 actively practicing physician assistants (PAs) in the United States. PAs practice medicine with the supervision of licensed physicians. Approximately one-half of all PAs work in primary care, while 18 percent of all PAs are located in areas under 10,000 population. PAs are on the front lines of health care delivery at every level of our health care system. PAs work in hospitals, managed care settings and physician offices in addition to the military, VA and Indian Health Service systems. PAs are one of the principal components of the health care workforce providing medical care to Americans.

APAP represents the 58 programs currently approved by the AMA's Committee on Allied Health Education and Accreditation (CAHEA). These 58 programs graduate over 1,700 PAs each year.

#### Overview

Mr. Chairman, PAs will help us achieve the promise of universal coverage offered by the Clinton health reform proposal. The legislation you are now considering contributes to this goal, but can also be strengthened in several ways. Specifically, the legislation must:

- Recognize PAs as an integral part of the services provided by physicians
- Assure an adequate supply of PAs for the future
- Promote effective utilization of PAs in all practice sites and settings by reducing obstacles to PA practice with physicians
- Increase use of PAs to improve access to care for such groups as the elderly and underserved, and
- Create an efficient and responsive bureaucratic structure to oversee implementation of current workforce policy and to develop new policy for the future.

#### Summary of Recommendations

In this presentation we will make the following recommendations:

- Retain recognition of PAs, now given in the proposed legislation, as a provider of physician services (Title I, Sec. 1112)
- Set aside a specific portion of the \$400 million in funding for "primary care physician and physician assistant training" specifically for PA education programs at a level higher than the current authorized level of \$9 million (Title III, Sec. 3071)
- Make PA education programs eligible for GME funds whether through the physician portion of GME or through a dedicated account for PA training (Title III, new section required)
- Assure that the expertise and experience developed by the PA
  profession in developing model state laws be included as part of HHS
  efforts in this area (Title III, Sec. 3071(e))
- Retain the provision extending Medicare coverage of PA services to all geographic areas (Title IV, Sec. 4022(a))
- Establish a uniform reimbursement rate for all PA services at 97
  percent of the supervising physician's fee, and make this change
  effective for 1995 (Title IV, Sec. 4022 (a))
- Replace the proposed provision regarding funding for nursing under the National Health Service Corps program with language that would double the current 10 percent set-aside of scholarship and loan repayment awards for PAs, nurse practitioners and nurse midwives (Title III, Sec. 3472)
- Modify the recapture provisions related to the personal tax credit for
  primary care PAs practicing in Health Professional Shortage Areas who
  are unable to complete the 60-month mandatory service period (Title
  VII, Sec. 7801 and Sec. 23, Primary Health Services Providers)
- Extend the tax credit to PAs working in underserved areas prior to 1995
   (Title VII, Sec. 7801 and Sec. 23, Primary Health Services Providers)
- Extend the tax credit beyond five years (Title VII, Sec. 7801 and Sec. 23, Primary Health Services Providers)

- Authorize Medicare bonus payments for PAs working in underserved areas (Title IV, Sec. 4115)
- Consolidate the functions of the councils and task forces created by the proposed legislation into one organization (Title III, Secs. 3001, 3062 and 3073)

The justification and explanation for these proposed changes follows.

## Recognition of services provided by PAs

The Clinton proposal places appropriate emphasis on the importance of workforce issues as part of its health reform proposal. If the goal of universal coverage is to be achieved, then national policy must focus on the production, organization and distribution of the services required to meet the expected demand for care.

Note, Mr. Chairman, that we use the term "services." We believe that the national debate on health workforce issues should focus first on the identification of the services to be considered as medically appropriate and necessary. Once these services are identified, attention should then be given to which health professionals are best able to supply the required services.

The proposal before you defines "health professional services" to include physicians and others legally authorized to provide physician services (Sec. 1112). The proposed legislation recognizes that PAs provide physician services of high quality that should be available to all Americans under health reform.

PAs are also included in the definition of "lawful health care provider," whose services must be covered under any fee-for-service plan offered by a regional alliance. Plans and alliances will negotiate reimbursement rates for PA services rendered to their patients.

Finally, PAs are specifically listed in the definition of health professionals who may be considered "essential community providers" eligible for certification. Thus, PAs will be a part of service delivery systems that will address directly the needs of underserved populations.

PAs work as part of a team with physicians and other health care providers to provide care across a broad spectrum of practice areas and sites.

The recognition of PAs as a core component of the team approach to health care delivery should be retained in health reform legislation.

We do not recommend that the legislation mandate the use of PAs or any other willing provider. The definition of health professional services as currently written will assure that medical services are provided by qualified individuals, such as PAs.

## Future supply of PAs

PAs represent a flexible and cost-effective way of supplying the services necessary to meet the demand for care likely to result from health reform. To assure an adequate supply of PAs, the provisions of the legislation relating to support for PA educational programs must be strengthened.

The core of all PA training programs is preparation for work in primary care. PAs receive much the same basic science and clinical preparation as physicians as is provided during the second and third years of medical school. All PA education programs must meet CAHEA approved criteria, which helps to assure not only the quality but also the homogeneity of PA training. In addition, all PAs must take a recertification examination every six years to maintain their national certification. The core of this test is primary care. No other health profession requires all of its members to be recertified in this fashion. No other health profession gives the emphasis to primary care that the PA profession does.

Historically, a large number of PAs have chosen to work in primary care. Currently, forty-eight percent of all PAs work in family practice, pediatrics, internal medicine or obstetrics and gynecology. If emergency medicine is included (PAs often provide the non-emergent care delivered through an emergency clinic), the proportion of PAs in primary care increases to fifty-seven percent.

But PAs are also very adaptable by virtue of their training. Increasingly, PAs are being used in specialty care. What is attractive about PAs to specialists is the PAs' understanding of medicine, their ability to enhance the primary care component of a specialist's practice, and their ability to learn quickly the in-depth knowledge and skills associated with specialty practice based on their training and individual competence.

PAs thus represent a useful and adaptable resource for the health care system.

It is also cost-effective to produce a PA. While it has been estimated that a PA can provide a significant fraction of a physician's services (some estimates are 80 percent or more), the cost of educating a PA is only about one-fourth that of educating a physician. Because PA training is only two years in length compared to four years plus residency for a physician, the supply of PAs can be increased quickly.

Despite the obvious value of PAs to the health care system and the cost-effectiveness of their training, only \$6.5 million is being spent this year through Title VII in support of PA education. This funding contributed to the production of 1,710 graduates last year. This total represents an increase over the amount appropriated each year for the previous ten years (\$4.9 million). The \$6.5 million for the current fiscal year also can be compared to the \$16.9 million appropriated to support the production of approximately 1,500 nurse practitioners and nurse midwives.

The proposed legislation authorizes spending \$400 million to cover "primary care physician and physician assistant training," plus programs for the training of underrepresented minorities and nurses.

We would request that a specific portion of these funds be set aside for PA education programs at a level higher than the authorized level of \$9 million.

Core support for PA programs, however, should come from a stable source that will not be subject to the vicissitudes of the appropriations process each year. The proposed legislation changes the financing of graduate medical education. Rather than coming entirely from the Medicare trust fund, physician residency training would also be supported by money set aside from private health insurance premiums collected by corporate and regional alliances. In a precedent-setting move, the bill allots \$200 million of these funds for graduate nurse education.

Given that PAs are trained to provide many of the services now offered by physicians, and that PAs represent a flexible and valuable resource as the health care marketplace responds to the challenge of health reform,

we would request that PA education programs also be eligible for GME funds either through the physician portion of GME or through a dedicated account for PA training.

#### Utilization of PAs

As already noted, the proposed legislation recognizes that PAs are essential to the delivery of health care under health reform. The bill includes language encouraging and supporting full utilization of the "professional education and clinical skills of advanced practice nurses and physician assistants."

A distinguishing feature of the practice of PAs is the *team approach* to health care. The team approach emphasizes the importance of coordination and communication among health care providers. It is not enough merely to "treat and refer." Patients are greatly disadvantaged by a fragmented system of care in which providers work independently and shuttle patients to and from separate sources of

care for individual problems. Patients should have one source of care for the majority of their health care needs. And the providers offering this care should be able to communicate easily and quickly with one another. This is the model of PAs and supervising physicians.

PAs practice medicine with a significant degree of autonomy yet still with the supervision of licensed physicians. Patients who are treated by a PA receive a wide range of services for a variety of different conditions. PAs not only treat patients but educate them as well. This role is essential to PA practice, and patients appreciate the time spent with them in this function. More importantly, PAs know and their patients know that PAs are part of a network of care. Consultation with a physician is as available as a phone call or a knock on the door of a nearby office.

Despite the strength of this practice, important obstacles remain to the full and complete utilization of PAs in a team approach to care remain. Specific obstacles would include:

- lack of prescriptive authority for PAs in some states
- overly restrictive supervisory requirements for PAs in some states, and
- lack of recognition by some third party reimbursers.

The proposed legislation authorizes the Department of Health and Human Services to encourage the adoption of model professional practice statutes for PAs, and to remove inappropriate obstacles to the effective use of PA practice.

We support this provision, but would request that additional language be included to direct the Secretary of HHS to consult with appropriate professional societies on the development of a model law so that the expertise and experience developed by the PA profession can be utilized on this project.

#### Access to care

#### Medicare

At the present time, there is no standardized basis for coverage of PA services to Medicare patients. Services are reimbursed at varying rates in different locations, and there is no coverage at all in certain locations.

Since 1985, a number of bills have been introduced in both the House and the Senate to standardize Medicare coverage for services provided by PAs in all practice settings at a uniform payment rate. HR 3600 amends existing law and extends Medicare coverage for outpatient physician services provided by PAs from rural Health Professional Shortage Areas (HPSAs) to all geographic areas. Reimbursement would be paid to the PA's employer at 85 percent of the physician's fee.

We support the provision extending PA services to all geographic areas.

However, reimbursement for PA services still varies considerably in other ways depending on whether the PA provides care in a skilled nursing facility or intermediate care facility, practices in a hospital (other than assisting at surgery), or assists in surgery. This inhibits the otherwise appropriate and cost-effective use of PAs.

## We would recommend that:

- a uniform reimbursement rate be set for all services
- the uniform rate be set at 97% of the physician's fee, and
- these changes be made effective in 1995.

The net effect of these changes would be to eliminate inequities in the reimbursement of PA services and to provide a positive incentive for the expanded use of PAs in the Medicare program. Expanded use of PAs, particularly in rural and inner city areas, would promote greater access to care for the elderly populations residing in these areas.

### National Health Service Corps

The proposed legislation increases funding for the National Health Service Corps scholarship and loan repayment programs. These increases would be very beneficial because there are presently far more applicants than can be accommodated through the current program. PAs have been very successful in competing for this financial aid, and have been a mainstay of health care for many communities participating in the program.

In addition to increasing funding levels, however, the bill requires that 20 percent of all NHSC participants be nurses. This change fails to recognize or give weight to the significant role that PAs have played in the NHSC in providing care to underserved areas.

We would recommend that the bill's provisions with respect to nursing be replaced with language that would increase the current 10 percent set-aside of scholarship funds to 20 percent for scholarships and loan repayments for PAs, nurse practitioners and nurse midwives.

#### Tax incentives

The legislation also contains a \$500 per month personal tax credit for primary care PAs practicing full-time in Health Professional Shortage Areas. This can be an

important incentive to attract more providers to underserved areas. To provide as great an incentive as possible for practitioners not only to go to shortage areas but to remain there as well, we would recommend the following:

- Modification of the recapture provisions for PAs unable to complete the 60-month mandatory service period
- Extension of this credit to PAs working in underserved areas prior to
   1995 (to help retain PAs in these areas)
- Extension of the tax credit beyond five years (also to retain PAs in these
  areas)

#### Bonus payments

In addition, we recommend that:

 Medicare bonus payments, currently available only to physicians, be authorized for PAs working in underserved areas

Tax incentives are an inducement to relocate to shortage areas, but Medicare bonus payments help retain providers in these areas. They provide some small financial adjustments to help cover the cost of delivering care to underserved elderly patients.

## Bureaucratic structure to implement workforce provisions

The proposed legislation would establish a National Council on Graduate Medical Education, a National Council on Graduate Nurse Education, and a National Institute for Health Care Workforce Development. Potentially, the creation of these three institutions could create confusion in terms of lines of authority and responsibility for workforce issues.

We recommend that Congress consider consolidating the functions of these three offices into one council or agency. We further recommend that all affected professions be represented on this council or agency together with consumers and payers.

#### Conclusion

Mr. Chairman and members of the committee, we believe that a national health care program should provide basic health care services to all residents. Further, we believe that the scope of such services should be determined by public policy and be

based on considerations such as medical effectiveness. Health services should be provided by qualified persons who practice in a team approach to care. Patients should retain a choice of providers and be satisfied with the quality of care offered by the providers and the health care system. Finally, we believe that the structure of a national health care program should be determined by Congress and administered by the states under national guidelines. We will support financing mechanisms that are fair, equitable, and include cost controls. We look forward to working with you in the further development of legislative proposals directed at these ends.

## PREPARED STATEMENT OF VIRGINIA TROTTER BETTS

Good morning Mr. Chairman, members of the Committee, I am Virginia Trotter

Betts, ID, MSN, RN, President of the American Nurses Association (ANA). The American

Nurses Association is the professional organization representing the nation's two million

registered nurses (RNs) through 53 state and territorial nurses associations. ANA is also a

labor organization, representing, through state nurses associations, more registered nurses in

collective bargaining than all other unions combined.

I appreciate the opportunity to testify today before the Senate Labor and Human Resources Committee on the Workforce Implications of Health Care Reform. We commend this Committee for providing a forum to begin to address the implications of health care reform on those who provide care. As you know, the health care industry is the nation's third largest employer, accounts for one-seventh of the nation's economy, and has been the largest creator of new jobs since 1980. Clearly, major shifts affecting this industry will have great implications for our nation.

This Committee, with jurisdiction over issues of labor and employment as well as health care reform, is uniquely positioned to address proactively the workforce needs of a new health care system. To move ahead with health care reform without anticipating the impact it will have on the current industry workforce would be like writing only the first act of a two-act play. We can't afford to wait until a new health care structure is set up to find out whether we have the qualified persons to deliver promised services. We commend you

for seeking answers to one of the most critical questions in health care reform: Will the skills of the nation's health care workers match the needs of the system?

Nurses are first and foremost patient advocates, thus, we look forward to the implementation of an inclusive, effective health care system. We know firsthand of the inequities and problems within our current delivery model. We know all too well that the system succeeds masterfully for some, yet fails shamefully for too many others. Professional nurses have always been the backbone of our nation's health care system—providing around the clock care seven days a week as both illness and wellness professionals. Nurses are the single largest group of health care providers. Registered nurses practice wherever people need nursing care—hospitals, nursing homes, schools, home health agencies, the workplace, community health clinics, in private practice and in managed care settings. The majority of nurses (two out of three) work in hospitals — the arena in which the most dramatic changes are taking place.

As you continue your deliberations on health care reform, we urge the Committee to consider the implications of the following workplace issues:

- 1. Changes in demand for health care under the Health Security Act will require an adequate supply of appropriately educated health care providers. Health care reform efforts must be accompanied by adequate retraining and redeployment of the current professional health care workforce if consumers are to fully benefit from a reformed system. This will include training and dislocated worker services as well as a dedicated funding stream for graduate nursing students to prepare for the increased need for advanced practice
- Hospital efforts to restructure and contain costs must be handled responsibly.
   Downsizing with increased reliance on unlicensed aides, without a full
  assessment of the impact on patient care, may seriously jeopardize patient

safety and access to quality services. Congress should enact interim quality protectors to safeguard patient care during this period of transition.

#### RETRAINING, REDEPLOYMENT AND EDUCATION OF THE WORKFORCE

Health care reform will accelerate the shift to a community-based system of care which will result in significant redeployment of the current nurse workforce. States will need to respond to the development of health alliance plans and the concomitant evolution of new jobs in primary, preventive, critical and community care arenas. ANA supports the provisions; in the Health Security Act designed to address these workforce issues. We support the development of the National Institute for Health Care Workforce Development. We believe that a body to analyze the workforce needs of a new health care system will be critical during this time of transition. The Institute would be made up of representatives from health care institutions, labor unions, educators, and consumers—all of whom have a stake in creating a health care system that works.

Different levels of training and education, from skill enhancement to additional academic education will be required for some nurses to transfer hospital skills to other settings. These are considerations for many acute and long term care nurses who will most likely not be adequately prepared to work in these settings. Funding must be made available to support the education and training of these nurses.

All nurses must have access to dislocated worker programs and benefits designed to assist dislocated workers. The dislocated worker initiatives which the President will send to this Committee in the coming weeks must be designed so as not to exclude those nurses who currently work part-time. Approximately one third of nurses work part-time. These nurses may be attending school or caring for their young children, but their income is critical to the support of their families. We are pleased to see support services, such as child care, included as an appropriate expenditure of funds in the Health Security Act and in drafts of dislocated worker legislation.

The escalating layoffs of nurses resulting from hospital mergers and closures point to the need for improved employee protections. ANA believes that any hospital's decision to significantly alter staffing levels or professional mix or to redeploy personnel should include:

1) advanced public disclosure of plans to merge, close, or significantly layoff personnel; and educational programs for professionals to prepare them for redeployment. ANA is pressing for a national health care reform transition plan to ensure that reform can be carried out without premature, reactive hospital closures, massive dislocation of employees, and serious threats to the quality of patient services.

ANA will continue to work with Congress, the Departments of Labor (DOL) and Health and Human Services (HHS) to ensure that retraining efforts focus on increasing the future workforce of professional providers and not unintentionally create a large pool of low-skilled health care providers.

The Health Security Act is currently the only health care reform proposal before

Congress which addresses the education and retraining needs of nurses. We believe these
provisions to be critically important and should be included in any health care reform
proposal which passes Congress.

#### GRADUATE NURSING EDUCATION

ANA is pleased to see that the Health Security Act includes a proposal for a dedicated stream of funding for advanced practice nurses. As health care reform reshapes our health care delivery systems, it will be essential to ensure that there is an adequate supply of advanced practice nurses to meet the needs of universal coverage.

The nursing community understands that the graduate nursing education program proposed in the Health Security Act needs to be refined. As a result we have formed a coalition to work on these issues. In November 1993, representatives from the American Nurses Association (ANA), the American Association of Colleges of Nursing (AACN),

American Association of Nurse Anesthetists (AANA), American College of Nurse Midwives (ACNM) and the National League for Nursing (NLN) agreed on a set of criteria that we believe should guide the formation of the dedicate funding stream for a graduate nurse education program. The criteria are as follows:

- ♦ The funding focus should be on educational support for all advanced practice nursing students, i.e., clinical nurse specialists, nurse anesthetists, nurse midwives, and nurse practitioners.
- Graduate Nurse Education (GNE) funds should not be used to support undergraduate nursing education.
- ◆ The GNE fund with a dedicated funding stream should provide at least \$200 million of new money in addition to the current \$300 million available to nursing and allied health under the graduate medical education program. The \$300 million is used largely to support nursing diploma programs.
- Funding through the GNE should be in addition to current authorizations under Title VII and VIII of the Public Health Service Act.
- Students eligible for GNE funds should be post-baccalaureate, advanced practice nursing students enrolled in a program that is linked to an academic institution.
- ♦ All providers (all clinical sites including nursing centers, hospitals, ambulatory care settings, home health agencies, etc.) that incur costs for support of advanced practice nursing education will have access to the GNE monies for student stipends, costs of clinical nursing faculty supervision at the provider site, and program expenses including salaries of support staff. The provider must have a written agreement with an academic institution.

 Classroom costs incurred by rural and urban underserved providers that have agreements with academic institutions should be reimbursed.

Currently there is one nurse practitioner available for every seven open positions. It is anticipated that under a reformed health care delivery system, that this need will grow.

Preliminary data from a study being conducted at the University of Wisconsin, under a Robert Wood Johnson grant, show that when nurse practitioners are used by HMOs, that the need for MDs decreased by 30 - 50 percent. The data also showed that the inclusion of the NP on the patient care team doubled the efficiency of that team. Full utilization of nurse practitioners will be essential to allow the health care system to absorb the 37 million uninsured population.

The current cost of attaining a nurse practitioner education is similar to students pursuing master's degrees in other areas. The American Association of Colleges of Nursing found that; based on 1988 dollars, it costs a graduate nursing student \$36,837 without financial aid to receive a master's degrees. Most graduate nursing students attend school on a part-time, basis so that they can "pay as they go". This method of attaining a graduate nursing education is in part because there is little financial aid available to these students. Establishing a GNE program would eliminate much of the need for these graduate students to work at the same time they are attending school, thereby increasing the number of advance practice nurse graduates in a given year.

We strongly urge this Committee to include a dedicated funding stream for advanced practice nurses in order to ensure an adequate supply of health care practitioners to met the needs of health care reform.

#### PROTECTING PATIENTS FROM UNSAFE CARE

ANA is concerned that the quality of care may be adversely affected by hospital cost savings strategies. Most hospitals are not waiting for health care reform to occur, but are

rapidly making adjustments aimed at lowering their cost structures, joining and forming systems of care to achieve economies of scale, and engaging in various initiatives to ensure greater financial stability. While these maybe be a necessary part of the transition to a future reformed health care system, we are concerned about the potential for deterioration in the quality of health care.

Over the past year, ANA has tracked a growing number of reports about changes in workforce patterns in the health care industry. There are increasingly frequent reports about changes in skill mix, abrupt and unannounced layoffs, increasing use of unlicensed, leaser qualified personnel to do work previously done by RNs, and hospital restructuring aimed primarily at saving money. We believe these are short-sighted actions that could have immediate consequences. Displacement of registered nurses is occurring as hospitals and health care facilities respond to the increased prevalence of managed care in the insurance industry and as hospital services shift to outpatient and community settings.

Layoffs are occurring at a time when the length of hospital stay has decreased, census is down but the acuity of hospitalized patients has increased. It is indeed a disturbing trend: the qualifications and skill levels of hospital staff are decreasing in an environment in which patients are sicker and hospital stays are shorter. The nurses who remain are under more stress with increased workloads. Unlicensed assistants are performing tasks that they are not trained to do. For example, it's one thing to delegate answering phones to unlicensed aides, but it's dangerous for a non-RN to monitor the vital signs of a patient fresh out of surgery. While this saves money, it poses risks to patients.

We know from well-documented research that there is a proven relationship between the level of staffing, richness of skill mix and patient outcomes. A higher proportion of RNs (akill-mix) is directly linked to quality patient outcomes including fewer patient deaths. In addition to morbidity and mortality, nursing care is linked to fewer complications, shorter lengths of stay and fewer patient days; hospital readmission within thirty days; patient falls; medication errors; use of restraints; and incidence of nosocomial infections, etc. Subjective measures such as patient satisfaction and quality of life are also affected. Happier patients are more compliant with treatments. Attached to this testimony is an article Prescott, a University of Maryland researcher, which discusses these issues is We request that this article be included in the record of this hearing.

ANA has had several meetings with key White House domestic policy staff
Departments of Labor and Health and Human Services officials regarding the importa
protecting patient care between passage and implementation of health care reform. AN
believes that Congress must enact certain interim quality protectors to safeguard patients.

part of a health care reform package. Such measures are essential in order to protect
patients from a significant and dangerous downgrading of nursing care in hospitals and
nursing homes because of short-sighted elimination of RN positions. Institutions that
markedly drop or change staffing in direct patient care areas should be required to account
for these changes to the Health Care Financing Administration (HCFA). Hospitals also
should be required to document their staffing plans and report to consumers, certifying
bodies and regulatory agencies the impact of redeployment on patient outcomes and quality
of care. Failure to comply with these requirements should give rise to a presumption that "
hospital is delivering unsafe care in violation of Medicare requirements.

#### CONCLUSION

Mr. Chairman, ANA supports health care reform that provides univer care, and balances the need to contain costs with the need to provide qua? Hospitals that are concerned only about saving money may find emple about saving jobs. Neither is the right approach. ANA has always endorsed the use of the most appropriate provider to meet the consumer's health care needs in every setting. Whether it is in primary health care services - which can be safely and appropriately delivered by qualified nurses - or acute care hospital and critical care services which require the experienced judgment of a registered nurse, the success of health care reform will depend in

part on matching the right provider to the need. We applaud this Committee for your strong commitment to developing a health care system that provides access to quality, affordable health care. As your deliberations proceed, we urge you to continue to address the education and training needs of the health care workforce and to take steps to protect the quality of patient care. The system cannot succeed without skilled nurse providers.

We appreciate this opportunity to share our views with you and look forward to continuing to work with you as comprehensive health care reform legislation is developed. Thank you.

[Whereupon, at 1:28 p.m., the committee was adjourned.]



# THE HEALTH SECURITY ACT: THE ROLE OF THE STATES

## WEDNESDAY, FEBRUARY 2, 1994

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 10:28 a.m., in room SD-430, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Metzenbaum, Mikulski, Wellstone, Wofford, Kassebaum, Jeffords, Gregg, Durenberger, and Hatch.

## **OPENING STATEMENT OF SENATOR KENNEDY**

The CHAIRMAN. The committee will come to order. I would ask Governor Waihee and Governor Leavitt if they would be good

enough to come forward, and also Carmen Buell.

We welcome both of our Governors here this morning who will be representing the National Governors Association, which recently concluded its annual meeting here in Washington. We are also pleased to have Massachusetts State Representative Carmen Buell, who is the House Chair of the Massachusetts State Legislature's Joint Committee on Health Care, and she will be testifying on behalf of the National Conference of State Legislators. I have worked with Carmen Buell on health issues for some time, and we are enormously grateful for all of her insights into the challenges that exist not only in our State, but in States generally. She is extremely well-informed and knowledgeable about these issues, and we are grateful for her presence and her testimony.

I will place my statement into the record and just say how much we appreciate the Governors' presence here today. We wanted to take advantage of the Governors' Conference to have a presentation about the role of the States and how they view the various alternatives, the President's program; and other issues which are related to this debate, and also to tell us about what is transpiring in

the States.

I also want to explain to the members as well as to the press that we do have an executive session agenda which includes the Organ Transplant Program Reauthorization as well as various nominations, and we will try and dispose of that when we get a quorum, so I will necessarily interrupt our witnesses to attend to that business, and I understand from asking our members that they support that procedure.

We have included on the hearing agenda today Ken Thorpe, who will be available to the committee to respond to a report that was issued today by the administration with regard to the cost savings of the administration's program to the States, some \$50 billion over a 5-year period which, if carried forward, would mean additional resources for education, law enforcement, and a reduced burden on taxpayers.

We had not had a prior announcement that that report was going to be out and available, but we understand, given the National Governors Meeting, that it was moved forward so at least that could be a part of their agenda. So Ken Thorpe will be available to the committee to respond to questions. I give assurances to the members that we will invite him back when we have had more

time to absorb the presentation and the report itself.

It seemed to me that given the fact that the report came out, and the issue before us is the question of the economic impact on the States, that we ought to at least have an opportunity to hear from Mr. Thorpe. So for that reason, on very short notice, he was included, and those are the circumstances. I can understand and respect my colleagues' concern over not having the advance text of the presentation and more notice, and those are the reasons that we have decided to move ahead. I thank the members for their understanding.

[The prepared statement of Senator Kennedy follows:]

# PREPARED STATEMENT OF SENATOR KENNEDY

Today the Committee will consider the role of the states in health reform. This is the second hearing the Committee has held on health care reform since the President renewed his challenge last week for Congress to pass a comprehensive reform bill.

Every home and every workplace in America feels the urgency of

this task.

Families live with the fear that the coverage they have today will disappear tomorrow if a family member gets sick or changes jobs. Workers see their annual pay raises swallowed by health insurance costs that are rising at two and three times the rate of inflation. And businesses suffer from higher production costs, lower competitiveness and more rancor at the bargaining table, all due to the rising cost of health care.

States are also burdened by the soaring cost of health care.

Like other employers, states have seen the cost of health insurance go through the roof. Nationally, states spent \$10.7 billion to insure their workers and retirees last year, up 45% over a three year period. In Massachusetts, the cost of insuring state workers has soared from \$195 million in 1986 to \$465 million last year—an increase of nearly 140 percent over that seven year period.

States are reeling from rising Medicaid costs. State spending on

Medicaid nearly quadruppled between 1983 and 1993.

And the more states spend on health care, the less they have to invest in their cities, educate their workforce, fight crime and meet other pressing social needs. In 1992, Medicaid absorbed 17 percent of state spending—that's six percent more than they spent on higher education and nearly five times what they spent on prisons. In

fact, states spend more today on health care than any other item

in their budget, except elementary and secondary education.

When the health care system fails, it is often state and local governments that are left holding the bag. Despite their stop-gap measures, nearly 40 million Americans are uninsured today, and two million more lose their health insurance every month.

States cannot afford to continue down this road. They need the relief that only universal coverage and cost control can bring. The Administration's plan offers this relief to the states and, in my

opinion, it is the only plan that does so.

Recently completed Administration estimates show that states will save more than \$53 billion between 1996 and the year 2000. By the year 2000, savings will be a whopping \$22.3 billion annually. Even if there were no other reason for passing the Clinton plan, these savings to hard-pressed state governments would be a strong argument for action. These savings represent more police on the street to fight crime, more teachers in the schools, and relief for overburdened taxpayers. We will hear more about how much states stand to gain under the Clinton plan later this morning.

Another key issue is the balance between federal and state powers and responsibilities in a new health care system. The Clinton proposal guarantees comprehensive coverage, a mandate on both individuals and businesses to purchase health insurance, new ground rules for the health insurance industry, and limits on how

much insurance premiums can grow each year.

States are responsible for key aspects of program's implementation. This includes the creation of the health alliances, certification of health plans and decision of whether or not to set up a singlepayer system.

Today we will hear how state officials, multi-state employers and health care providers believe responsibility and authority should be

allocated under health reform.

Governors Mike Leavitt from Utah and John Waihee of Hawaii will be leading off the hearing this morning, along with Massachusetts State Representative Carmen Buell. I was pleased to see that the National Governors Association adopted a resolution on Monday calling for Congress to pass a health care reform bill this year. The governors clearly recognize the urgency of dealing with the health care problem.

I welcome the governors' testimony and the testimony of our

other witnesses this morning.

The CHAIRMAN. I want to say what a pleasure it is to welcome Governor Waihee to the committee. I have had the good opportunity to have known the Governor for a good number of years and have had the good fortune to have had many long and fruitful discussions with him on what has happened in the State of Hawaii historically and currently. He has—as I am sure all Governors have—spent really an extraordinary amount of time on health and health care issues, particularly on preventive health care issues. We are looking forward to his testimony.

And I have been reading with interest Governor Leavitt's presentations and his involvement at the Governors' Conference, and since he is a good friend of our friend, Senator Hatch, we all imme-

diately have enormous regard and respect for you. I sincerely want

to thank you very, very much.

I recognize our friend and colleague, former chairman of this committee and ranking member, Senator Hatch, for whatever introductions and comments he may have.

## **OPENING STATEMENT OF SENATOR HATCH**

Senator HATCH. Thank you, Mr. Chairman, for this courtesy, and other members of the committee. I have to admit that I am slightly biased toward this one witness on the panel today, our own Gov-

ernor Michael Leavitt.

I want to make sure that the committee is aware of his outstanding credentials. Governor Leavitt is here not only as Governor of the State of Utah, but also with Governor Waihee as representatives of the National Governors' Association and its health leadership group.

ship group.

Mike Leavitt is widely recognized as a top-notch expert on State health care reform efforts. In fact, his expertise is so much in demand that he has been asked to testify before the Finance Commit-

tee tomorrow.

I will tell you why Mike Leavitt is so knowledgeable. He has served in local, regional, and State Government positions, giving him an unparalleled sensitivity and insight into the public's expectation about health care delivery. He is also a former insurance executive, so when he talks about the challenges and potentials of insurance reform, you are hearing the well-considered views of an experienced professional there as well.

One of Governor Leavitt's first actions after he was sworn in a year ago was to initiate a top-to-bottom review of health care in Utah and how it could be improved. That review has formed the basis of his "Blueprint for Market-Oriented Health Care," which I am sure he will discuss with us today and of which I am sure, Mr.

Chairman, you are well aware.

So we Utahans are very honored that the committee has recognized the considerable talent at this table today. I know that Governor Leavitt, Governor Waihee and Representative Buell will provide the committee which a very beneficial perspective which is critical on our deliberations on health care reform.

So I am happy to introduce our Governor to you today, and I really believe it will help us to listen carefully to what he has to

say.

[The prepared statement of Senator Hatch follows:]

## PREPARED STATEMENT OF SENATOR HATCH

Thank you, Mr. Chairman.

I must admit that I am slightly biased toward the lead witness on our first panel, our Utah Governor Michael Leavitt.

I want to make sure the Committee is aware of his outstanding

credentials.

Governor Leavitt is here, not only as Governor of the State of Utah, but also with Governor Waihee (WHY-HAY-AY] as representatives of the National Governors' Association and its Health Care Leadership group.

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We Utahns are honored that the Committee has recognized the considerable talent at this table today; I know that Governor Leavitt, Governor Waihee [WHY-HAY-AY] and Representative Buell will provide the Committee with a very beneficial perspective which is critical in our deliberations on health care reform.

Mr. Chairman, the role of the States in health care reform is one

of the most fundamental issues we will consider this year.

If you happen to share my belief that there is not a "one size fits all" answer to the myriad problems we have with health care, you can see each state reform initiative as, in effect, a laboratory of learning. And each initiative, whether it is in Hawaii, Utah, Massachusetts, or any other State, will yield valuable information on

a range of issues.

At the federal level, we must be extremely careful to design approaches that are sensitive to State needs. I am sure many read a story in the Washington Post this weekend indicating that the national state budget officer association provided each member with a 110 page workbook. That's how many pages it takes for a State to determine the impact of the President's Health Security Act on that state's budget!

The article reported that, for the past three months, Virginia has had its budget analysts working through the budget workbook. They concluded that the President's plan could cost the state an extra \$441 million in Medicaid expenses. Or, it could cost \$212 million. It all depends on what impact the plan would have on Virginia's Medicaid eligibility rules, and no one knows the answer!

I know that the Chairman and members of this Committee share my view that any reform proposals we consider must be sensitive to the needs of the particular States. I am confident that the testi-

mony we hear today will guide us in that endeavor.

The CHAIRMAN. Thank you very much.

Governor Leavitt, as you know, Senator Hatch has been one of our real leaders, not only in this committee but in the Senate, on health care, particularly in terms of the down-wind issues, which he recognized, and in terms of home care, nutritional supplements, and other issues. So he has been very active and involved.

We look forward to your testimony, and we ask you if you would

be good enough to start off.

STATEMENTS OF HON. MICHAEL LEAVITT, GOVERNOR OF THE STATE OF UTAH, ON BEHALF OF THE NATIONAL GOVERNORS' ASSOCIATION; HON. JOHN WAIHEE, GOVERNOR OF THE STATE OF HAWAII, ON BEHALF OF THE NATIONAL GOVERNORS' ASSOCIATION; AND HON. CARMEN BUELL, MEMBER OF THE MASSACHUSETTS HOUSE OF REPRESENTATIVES, GREENFIELD, MA, ON BEHALF OF THE NATIONAL CONFERENCE OF STATE LEGISLATURES

Governor LEAVITT. Thank you, Senator, members of the committee. I am delighted to be here today representing the National Gov-

ernors' Association, with my colleague from Hawaii.

Today we will really focus on four things between us. The first is the new National Governors' Association policy; the second will be the mutual roles that we see between States and the national Government in being able to supply health care to our citizens; the third will be the Governors' reaction to the Clinton administration plan, and also potential impacts of reform financially on our respective States.

I have submitted a copy of my statement for the record, Mr. Chairman, and I would be happy just to summarize that and then go directly from there.

The CHAIRMAN. Please.

Governor LEAVITT. May I say that we as Governors firmly believe that to provide health care, there are respective roles for both the national Government and our individual States. We believe that there is a dramatic need for us to have tools on the State level to be able to do our part of that job. We need to have those tools, we need to have timetables, and we need to have broad frameworks on which to operate.

At our last meeting, which adjourned yesterday, we adopted a statement that Governors from North, South, East, and West all agree, and I would like to review those points quickly with you.

First, Governors are in agreement that we need to have insurance reform and are prepared to accept some minimum standards with things such as portability, guaranteed renewability, limitations on medical underwriting, so that we can all work together to establish flexible plans and also then have the capacity to implement cooperative buying arrangements.

We have put forward a statement on State organized purchasing coops, and the need that will be evident in many States for those, and in fact, virtually every State, but we need tools to be able to

establish those.

We are prepared to put forward a position on core benefits and access to them, and the tax deductibility of health care premiums that is necessary, the tools that we need in order to be able to make our State plans work.

It is also evident that we will need to have low-income subsidies and some access and utilization of the Federal capacity that you

have for income redistribution.

We need changes in the current Medicaid system, the capacity to be able to use capitation and other competitive means within that system, and also the capacity to have flexibility to enlarge the population that is served by Medicaid. In addition, we need to have some relief from the Boren amendment, that in many cases causes us to be unable to control cost and reimbursement rates in institutional health providers.

Medical malpractice reform is another area that we have focused on and feel that there is some need for standards on, and relief

from some antitrust statutes.

One area that I would like to focus on in this committee is the need that we feel for some relief from ERISA. We have not taken a position that we should have a repeal of ERISA. In fact, most of us believe that it serves a very important and practical purpose.

But there are some flexibilities that are needed.

I have put forward, as Senator Hatch indicated, in our State, and many other States are moving forward, what we call "Utah Healthprint." It is a blueprint for market-oriented health care, but it is dependent in many cases on being able to have some flexibility in ERISA. For example, our health plan calls for the development of a cooperative buying arrangement, and it calls for us to do away with pre-existing conditions. But our problem is that if we are not able to impose the same kind of pre-existing condition responsibility on those plans under ERISA as we do on those under State-regulated plans, we still have not solved the problem. That is one example.

Another example. Our plan calls for aggressive actions to be able to improve quality and the level of information that can be provided to our citizens. Our vision of our cooperative, for example, would be for every citizen who is served by it to not only receive pricing from various health plans, but also quality information on the level of quality being received by various participants as well as customer satisfaction. Without the capacity to require those served currently by ERISA plans, we are without the capacity to

do that

We are developing what we believe will be the largest wide area network in the world in our State, that will ultimately have some 100,000 devices hooked to it. Among those, we believe, will be all health care providers—hospitals, doctors' offices, clinics, even individual doctors, giving them the capacity to move to access databases that would have patient care records, electronic billing information, as well as quality information, allowing us to do quality research and provide that information to all citizens of our State.

At this point, one option in being able to finance that would be a quarter of one percent premium tax. That is not a formal part of our plan, but we anticipate at some point, it could become that. I do not have the capacity as a Governor to be able to make that across-the-board because of ERISA. Again, we do not ask for a full repeal of that. We recognize that it is a very important part of the health care system in our State. But it is that kind of flexibility and that kind of tool that we need in order to implement the kinds of plans we are talking about the kind of administrative simplification that would be part of those plans.

I will defer now to my colleague to talk about our reflections on the Clinton plan and any other potential financial impacts it could have, and then we would be happy to respond to any queries that

you might have.

The CHAIRMAN. Thank you very much.

Governor, could you hold for just a moment so that we might be able to consider the committee's business. I apologize to you.

Governor WAIHEE. Certainly.

[Whereupon, from 10:43 a.m. to 10:46 a.m., the committee recessed for business in executive session.]

The CHAIRMAN. Governor Waihee, we are delighted to have you here, and we look forward to your testimony.

Governor WAIHEE. Thank you, Mr. Chairman.

It is my intention this morning to relate to the committee the Governors' reactions at this time to the President's Health Security Act.

Like most Americans, the Governors gave high marks to the President for putting health care reform on the top of our national agenda. Governors are also appreciative that the President proposed a State-based system. The Governors support the States' discretion on the number and regional boundaries of alliances. This will enable individual States to consider how their provider com-

munities and local governments are organized.

We support the anti-discriminatory language in the Act, and if necessary would also support stronger language to give the States broad flexibility on this issue. However, at the very least, we believe that there should be at least a provision that would allow the division of Metropolitan Statistical Areas, or SMSAs, in the formation of these alliances. It may be important for a State, for example, to combine a metropolitan area with a rural area to get the right base to make the alliance effective, or to cross State boundaries to make alliances work. Finally with regard to this issue, the Governors support the flexibility to decide the legal entity that will govern the alliances, whether it would be a State agency, a quasigovernmental agency, or even in many cases, a private nonprofit organization.

Also, the Governors prefer the ability to contract out many parts of the States' operations to the private sector, and we would like legislative language in any final Act that would allow this option.

We also support additional flexibility to pursue alternative reform proposals so long as the goals of access, quality, and cost containment can be met. Subsequent to my comments in this particular part of the testimony, you will see, between the States of Utah and Hawaii, two very different yet in some respects very similar approaches to meeting health care. We would like the flexibility, assuming that we can meet the objectives of the health care reform movement, to be able to pursue different types of systems.

We believe it is critical that States have authority over the alliances to ensure a cost-effective system. And we would suggest that the Federal Government provide appropriate guidelines in this respect, rather than direct oversight over the alliances as such.

And while Governors may differ on the need for setting fee-forservice rates, we appreciate the ability for States to set rates for the entire State, or to have them vest this authority in regional al-

liances as appropriate.

Finally, it appears that States are ultimately responsible to ensure that individuals have access to health care. Governors are very concerned that this provision would evolve into States having

financial responsibility in the event of insolvency problems for alliances, or if the Federal Government's contribution reach the caps discussed in the President's proposal. States also have some fears that costs will be shifted to States, or that benefits will be increased without additional funds. These are traditional concerns of Governors.

With regard to premium caps, the Governors' policy supports budget targets in the early years of national reform rather than immediate enforceable premium caps, as detailed in the Health Secu-

rity Act.

While urging caution, the Governors do support the provision in the Act that gives financial incentives to States to try to bring alliance spending in under the budget. Without this incentive, one can expect that each alliance may negotiate premiums that are equal

to the premium cap set by the national health board.

Regarding the transition to the system, we think that there are a number of States that can begin implementing a new system as early as January 1st, 1996, with all States participating within 2 years. The deadline is ambitious, but we think it can be met with the additional planning and start-up funds detailed in the legislative text. In fact, some States would prefer operating a national system even before the start-up date, myself included as one of those.

The Governors support community-based alternatives to institutional care as far as long-term care is concerned, and the Act has several provisions which are consistent with that position. One concern is that the Federal financial participation, though significant,

is capped, whereas again, State exposure may not be.

In terms of potential economic impact, it is our belief that any proposal that significantly reduces the rate of increase in health care costs will have a major positive, long range economic impact. This is because health care costs are virtually bankrupting all three levels of Government and may be creating a drag on the

United States' competitiveness.

With regard to short-term costs, while the long-term impact is positive, there is considerably less certainty about the potential for short-term impacts. The collective impact is hard for us to quantify. It may depend substantially on the following: No. 1, the underlying strength of the economy when the health care reform is implemented; 2) the length of the transition period; 3) the flexibility for States and the private sector to make adjustments; 4) the amount of what I guess we would call "slack" in the health care system.

To make this analysis a little bit more precise, the National Governors' Association is currently undertaking a State-by-State study of what we believe the cost impact would be for each State, and that will be ready within about 4 weeks, and we would be glad to

make that information available to the committee.

Those, in a very summarized fashion, Mr. Chairman, are some of the highlights of our reaction to the President's plan which you have before you for consideration. Obviously, there is more detailed testiment on these items presented to your committee.

testimony on those items presented to your committee.

In addition to that testimony that I have provided on behalf of all the Nation's Governors, both Governor Leavitt and myself would also like to present some special perspective that we have

on the development of health care reform in our respective States. I think that you will get from our discussion of where we are going in our States that while we are able to meet very similar objectives, while we are able to use in some respects similar approaches, we do have differences that in a sense underscore the diversity of health care reform across the Nation.

The Hawaii system essentially is set up so that Government provides the rules and the objectives for health care in our State, and we rely on the private sector to develop or to deliver the health

care in the most cost-effective manner.

The cornerstone of our system is obviously an employer mandate, something that Hawaii has grown very comfortable with. As a result, we believe, of our approach, we have the most cost-effective health insurance system in the country. There are two reasons for that, we feel—first of all, because under our system, everybody pays, so that you do not find an awful lot of, or as much, cost-shifting as you would in many, many other States.

The second reason, and something we feel very strongly about and something I know your chairman and this committee feel very strongly about, is that we feel that much of our positive statistics regarding cost can be attributable to the fact that our system's employer-based foundation emphasizes or results in a high degree of

preventive and primary care.

Hawaii enjoys a hospitalization rate, for example, that is onethird of the national hospitalization rate. Our emergency room utilization rate is about one-half of that of the entire Nation. So the people in my State are very, very oriented to going in and getting early diagnosis and treatment. Indeed, in Hawaii, it is said that if your child coughs, you immediately take him to the family doctor. We have discovered over the years that that allows us to have a

much more cost-effective system.

By the way, as an aside, the part of our system that may not have taken advantage of primary care as much as we would have liked it to is in the area of Medicaid. That primarily relates to the fact that the reimbursement rates for doctor visits in Medicaid were so much lower than the private sector's rates, and therefore, there was a built-in disincentive for early doctor visits. What we found in that kind of a model was that people tended to go to hospitals and use emergency rooms where the cost of medical treatment was so much higher a lot more readily than they did where people had private insurance. We are hoping to turn that around with our new HealthQUEST program.

Probably the more important statistics, though, that result from the emphasis on primary and preventive medicine, are the health statistics that we enjoy. Hawaiians are not particularly known for their enthusiastic endorsement of a very rigorous life style with regard to activities that most people would consider healthy. We enjoy the good life. Yet we have some of the best health statistics in the Nation, and we feel that that is the result of primary care.

Now, one of the controversial areas regarding our employer mandate is its impact on small business. We have, I think, over the years discovered that the evidence shows otherwise; that actually, the employer mandate has levelled the playing field for businesses

in Hawaii.

That playing field that I am referring to is that generally speaking, in many other areas, what you have is especially a small business paying for the cost of insurance, and its competitor down the street not having that cost involved in their business expenses and then having an undue advantage over the business that decided to have health care insurance. Not only is that a disadvantage, but generally speaking in those situations where a business provided health care insurance and its competitor did not, the person who bought insurance was actually paying or compensating for the fact that their competitor did not have any insurance because the insurance cost included the cost of uncompensated care. So the employees who had no health insurance at the point where they ended up in the hospital without health insurance, thereby entailing the most expensive kind of medical care, did it at the expense of the person who had insurance at the front end, whose costs went up because the hospital charged them for the uncompensated care of somebody else's employee. As a result, we think that businesses benefit when everybody pays into the system.

Also, it has been our experience that the way we handled the employer mandate for situations where the cost of health care insurance may in fact affect a business' viability was the establishment of a premium supplementation fund. In 1974, we established this \$1 million fund, and it has actually been an embarrassment to the extent that during the 20-year period, we have only had to spend about \$80,000 of that fund to help about three businesses. The interest off of that fund has generated more revenues than we have had to expend to actually supplement businesses. And from time to time, our legislature proposes the abolition of that fund, because

they would love to use the money for other things.

Finally, there was a period of time in Hawaii between 1980 and 1982 where the employer mandate was in fact ineffective, or actually, unconstitutional, and we had no enforcement power to implement it. Yet during that entire period, I know of no small business that dropped its insurance, or any new business that did not buy health care insurance. So it has been a pretty much accepted practice

Second, in addition to our employer mandate, we have recently submitted a health alliance bill to our State legislature. Our proposed alliance is structured to meet the national goals with a mechanism tailored to our State's own health care system. I would similarly recommend, as I did indicating the Governors' feelings on this matter, that the alliance piece in Federal legislation give the States the flexibility to develop alliances that meet their needs, as long as they adhere to well-defined Federal objectives.

In other words, an alliance structured to serve in New York or California, or indeed, Hawaii, may not meet the needs of other States.

Third, as a Governor from a low cost State, we have concerned about the proposed premium caps. States that have been inefficient in the past may be more able to meet those premium caps than some of us who maybe penalize for doing things that reduce costs in the initial years.

We would also like to applaud the direction the administration's proposal is taking in Medicaid, with this one caveat, that there ap-

pears to be an attempt to leave some of the vestiges of Medicaid intact, and we feel that this may cost States, including Hawaii, undue administrative burdens.

Fifth, we need the flexibility to make health care reform happen, and we believe that the flexibility emphasizes results over process.

My final point this morning, Mr. Chairman and members of the committee, relates to a subject that I know is close to all of your hearts. I do want to thank you for your commitment to public health, a commitment that has been so effective and evident throughout the years. Your efforts are based on a very simple truth: We can pour uncounted billions of dollars into health care and still miss the mark if we do not deal aggressively and positively shore up America's public health infrastructure. We have to deal with threats like HIV, tuberculosis, illegal aliens, and other disadvantaged groups, and we want to first of all thank you for your efforts in these areas in the past and tell you that if health reform is to succeed, it needs to be in addition to rather than something that will take away necessary public health infrastructure throughout the Nation.

Thank you very much again, Mr. Chairman, for this opportunity.

The CHAIRMAN. Thank you very much.

[The prepared statements of Governors Leavitt and Waihee may

be found in the appendix.]

Senator MIKULSKI. Mr. Chairman, regrettably, I cannot return to the committee after the vote because of a need to go to the White House on drug issues affecting Maryland. I would like to be able to put my statement in the record because it describes the Maryland plan and how it has achieved, through an all-payer system, access, market reform, small community rating, no discrimination for pre-existing conditions, cost containment, quality control, and tort reform.

That is why I support State flexibility and look forward to working with the Governors' Association and the State legislatures, because they have been the incubator of new ideas, and they also know where the pot-holes and derailments could occur in achieving

both universal access and universal coverage.

The CHAIRMAN. Thank you very much. The Senator's statement will be so included.

[The prepared statement of Senator Mikulski follows:]

## PREPARED STATEMENT OF SENATOR MIKULSKI

Good morning. I am very pleased to be at this hearing on the role of the states in health care reform. This is an important issue for many states including my own. I look forward to hearing what other states are doing to meet the health care needs of their own residents. I am also very interested in whether you think there is enough flexibility in the Clinton plan for you to achieve the goals of your own state reform as well as to achieve the goals that the President has outlined.

I like what is going on in my state. Maryland has been a leader on controlling costs for the last 17 years through its all-payor hospital system. It is the only one of its kind in the United States. The all-payor system mandates that all payers reimburse a hospital at the same rate for the same procedure. This has reduced the problem of cost-shifting from the private to the public system. Maryland now has the least expensive cost per hospital admission in the

United States.

Maryland has had a lot of experience regulating health care costs. The Health Services Cost Review Commission sets the rates for hospital reimbursement. And just last year, the Maryland legislature passed a health care reform package which folded this body into the Health Care Access and Cost Commission to implement new reform. The Maryland legislature enacted a law that reforms the small business insurance market. It requires community rating and insurers must offer a standard package of health insurance benefits to small businesses with 2 through 50 employees must be offered. It establishes a minimum benefits package. The legislation will also establish a health care data base so we can see what the impact of these changes will be as we go forward.

These changes and other provisions of the bill have the potential for real change for Marylanders. More people will have access to

affordable insurance.

The new Maryland law is a big step forward, but just the first step. The movers and the shakers on health care in my state are now working to toward ever more comprehensive reform. They want to be the first to enact universal coverage, not the last.

Right now, Governor Schaefer, members of the Health Care Access and Cost Commission, public health directors, state Medicaid directors, representatives from the Department of Health and Mental Hygiene are all working together to take the next step. They have promised to come back to me in April with the state legislation to make health care reform in Maryland more comprehensive. I want to make sure that states get enough flexibility to deal with their own regional problems in the most appropriate way while meeting all the goals of the Clinton bill.

I believe that if a state can "guarantee every resident private health insurance that can never be taken away," we should explore the possibility that the state be allowed to follow paths already in

progress. I look forward to learning from other states today.

Thank you, Mr. Chairman for holding this hearing and I look for-

ward to the testimony from our distinguished panels.

Senator METZENBAUM. Mr. Chairman, I think I will return following the vote, but I wanted to say, while my very, very good friend Senator Mikulski is here, and someone with whom I probably disagree only about 2 percent of the time on votes, normally, that I have some very strong reservations about the ability of the States to do an adequate job. I do not think you have done an adequate job in the area of insurance. Hawaii has done a great job in the area of health care insurance. But I will return after the vote, and I hope I will have the time to point out that I think turning back to the States for more regulation in this area would be a major mistake. I cannot tell you how strongly I feel about the failure of the States to regulate the insurance industry adequately, and that includes health insurance, but I think I will need more time than just this moment.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

We are delighted to recognize Carmen Buell. We will have to recess in just a few moments, but maybe we could start with your testimony while other members are here.

Ms. BUELL. Fine. Thank you, Mr. Chairman and distinguished

members of the committee.

It is a wonderful position for a State legislator to be sort of "hitting cleanup" in the power hitter's position after two Governors, so

I relish the fact of my position on this panel.

Before I proceed with a summary of my testimony, I would just like to take a moment publicly to thank the chairman, my own senior Senator from Massachusetts, for his consistent and compassionate leadership on the health reform issue over the years and to let you know, Senator, that the people of Massachusetts are very grateful for your leadership on this issue.

Recently, the Massachusetts Hospital Association conducted a survey of Massachusetts residents to determine their support for the President's plan, as well as their support for the implementation of Massachusetts' own universal coverage law, Chapter 23, which is our employer mandate. Sixty-two percent of the respondents were in favor of the Clinton plan, and 67 percent of the respondents were in favor of us implementing our employer mandate.

But equally compelling as those statistics were the statistics about the unease that exists in Massachusetts and, I believe, across this country about the specter of being without health insurance. Fifty-three percent of the respondents indicated their concern and their future anxiety with losing their health care benefits because of moving on a job or losing a job or for a catastrophic illness. I think those statistics speak very loudly of the need for those of us in the Governors' offices and State legislatures and here in Congress to act this year on health care reform.

I would like to make three points with regard to the States' role in health care reform, and I will be echoing much of what you hear

from the Governors who preceded me.

First of all, I want to talk about Federal-State partnerships and endeavor to elevate the concept of federalism to the forefront of the health care reform debate. My colleagues in the legislature in Massachusetts and my colleagues in State legislatures across the country feel very strongly about the importance of developing a health care system that has as its cornerstone an equitable working relationship between State Governments and the Federal Government.

As our dearly departed friend Tip O'Neil reminded us again and again, all politics is local. Well, that is especially true in health care politics. The politics of health care are intricately linked to

neighborhoods, local practitioners, and local institutions.

In addition to the local nature of the health care delivery system, there is experience and a depth of knowledge that exists in State legislatures and in the Governors' offices with regard to health care. Plain and simple: States know health care. They are involved in every aspect of health care—in public health programs, in health care financing, in policy and regulation. Indeed, it is the States that have been the laboratories for health care reform.

Strong Federal-State relationships and partnerships are also important because there is such an enormous difference that exists between and among States, politically, institutionally, and demographically, and it is for these reasons that I believe we must have the flexibility in this partnership. And I want to just give four

areas where I believe we need to have that flexibility.

The CHAIRMAN. We will start off with those when we return from the vote. This is a dynamite start, and we look forward to the remainder of your testimony. We are down to about 3-1/2 minutes for the vote, and I am sure you are familiar with those procedures.

Ms. BUELL. Fine. Absolutely.

The CHAIRMAN. I thank our Governors for their patience as well. We will recess for the vote.

Senator METZENBAUM [presiding]. Ms. Buell, I understand you were in the midst of your testimony, and you lost the committee. Please proceed.

Ms. BUELL. Thank you very much, Senator, and as a chair of a legislative committee. I am neither insulted nor surprised by the

occurrence.

I was talking about the concept of federalism and partnership with States that you indeed have some concern about. But I want to articulate four areas which I think prove the need for flexibility and this partnership between the States and the Federal Government.

Certainly, the Governors who preceded me talked about Medicaid, and legislators are also interested in looking at the roles of not only Medicaid, but Medicare programs, and perhaps piloting or folding those into a comprehensive health care reform initiative at the State level.

The second area of flexibility has to do with the design of multipayer or single-payer systems at the State level, especially with respect to the provision of risk adjustment, subsidies and

mandates.

The third area of flexibility includes improving access to care for rural, urban, and inner-city populations, and that speaks to the local nature of health care delivery. This includes the identification, designation and protection of essential community providers.

The fourth area is the way that States are allowed to approach cost containment and financing mechanisms. Different States are going to approach those areas differently.

And the fifth area is experimenting with regional approaches to implementing reform. This past weekend, New England legislators from the six New England States met to see if there were common areas within the regional area of New England that we could tackle with regard to health reform, and surprisingly, we came up with six or seven or eight areas. This includes legislators from New Hampshire as well as Massachusetts and Connecticut, bipartisan efforts, and there are areas where regional approaches would probably make sense.

For the reasons that I just outlined, it is clear to me that any plan that emerges from Congress must embrace and build on the

concepts of federalism and partnerships with the States.

The second point I would like to make concerning the role of States in health care reform is the necessity of guaranteeing universal coverage. The swirl of debate on health care reform has produced primarily two distinct schools of thought. Some espouse the

theory that we should take steps to contain health care costs before undertaking universal coverage. Others maintain that guaranteed national health insurance must come first because we cannot achieve true cost containment without first insuring everybody. I fall uncategorically into the second camp. From my perspective, cost containment and universal coverage are inextricably linked and interdependent. If we only deal with cost containment, we will inevitably see diminished access for certain groups. The easiest way to contain cost is to exclude people from coverage.

As long as we allow exclusionary practices as a cost containment option, we will not sufficiently pressure the system to produce savings. Also, history has shown that piecemeal efforts to contain cost in one sector or for one payer only causes the balloon to bubble out

in other areas.

Therefore, I urge the Congress to provide a mechanism for universal insurance coverage through a standard, nationally-defined benefit package. Without this national plan, individuals will continue to rely on State-funded insurance programs and free care,

which financially strains State coffers.

Therefore, universal coverage is important for another reason. It is needed to relieve the enormous financial stress States now experience from the cost of covering the uninsured and the underinsured. To their credit, States across this country have developed a variety of programs to meet the needs of people without insurance and without access to basic primary care and preventive services. In Massachusetts, we spend more than \$570 million for these health services and health products for the uninsured and underinsured. Obviously, these resources could be used elsewhere—for job generation, for education, for aid to our cities and towns, for public health programs, and for many other critical programs.

States need relief from these fiscal burdens, and relief will only come when Congress enacts a standard benefit package with feder-

ally-guaranteed health insurance for all.

There is one other area that I would like to mention with regard to the States' role in health reform, and it has been mentioned by the two Governors. That includes the issue of ERISA. Obviously, I would talk about Medicaid, but that has been mentioned, and the

NCSL document that I provided detailed that.

There are four areas that I want to talk about with regard to meeting flexibility under ERISA if there is no national plan. States cannot ask self-insured employers to pay premium contributions for health care benefits in a multipayer or single-payer system under the present ERISA prohibitions. States cannot ask self-insured employers for health care information, as was mentioned. States cannot ask self-insured employers to provide a common standard benefits package for their workers to make sure that all workers in the States have the same kind of package. And States cannot ask self-insured employers to abide by insurance market reforms of guaranteed issue and guaranteed renewal. This restriction places in a very difficult position high-risk employees, such as AIDS patients, who may lose coverage in self-insured employers.

The magnitude of the dilemma facing States as a result of ERISA cannot be overstated. In my mind, the ultimate fix lies in

passage of national health care reform, and comprehensive reform. If that is not done, Congress must amend ERISA, permitting

States to have that flexibility.

I appreciate the opportunity, Mr. Chairman and members of the committee, to share my views with you and to present the documents on behalf of NCSL, and I believe I speak on behalf of all my colleagues in the Massachusetts legislature, and clearly, with legislative colleagues across the country, to pledge our commitment to work with you and Congress to craft a national health care reform that has as its cornerstone federalism and partnership with the States.

Thank you. [The prepared statement of Ms. Buell may be found in the ap-

Senator METZENBAUM. Thank you very much, Ms. Buell.

I am looking at the clock, and it is 11:45, and there are still five witnesses to be heard, and I am not sure even who is going to be able to preside after 12:30, but I think we can probably find some-

body.

I think some members of the committee have questions, and I know I have some concerns with the Governors' position, but I think I am going to waive my questions, and if it is agreeable with you, possibly send letters to you and ask for your responses in writing. I apologize for that procedure and to you also, Ms. Buell.

So I will say thanks to the three of you, and unless my colleagues from Pennsylvania or Minnesota are bursting with demanding

questions, I think we will proceed.

Senator DURENBERGER. I have questions, Mr. Chairman.

Senator METZENBAUM. One?

Senator DURENBERGER. Well, I have two witnesses coming up also, but I do not want to get caught in a bind that I cannot ask questions—we have Governors coming from all over the country; John comes a longer way than most—and I would like to have the opportunity to ask at least a couple of questions.

Senator METZENBAUM. Please proceed. Senator DURENBERGER. Thank you.

Mr. Chairman, I agree with you and I have been at this intergovernmental business for quite a while—I guess I chaired the intergovernmental relations subcommittee around here when we had one—so I do not come to this naively. And when I look at the records of the States—and several people have said the States are laboratories of reform—when I look at the records of the States in terms of expenditure, quality of life, and all the rest, I would suggest that people go to Utah, and I would suggest that people go to Hawaii, and I would suggest that people go to Hawaii, and I would suggest that people come to Minnesota and New Hampshire and a few States like that, and find out how, before State Government got involved in trying to do their "MINCares" in my case and some of these other things, how we were so successful in Utah to get such high-quality care at such a low price.

Somebody will say they are all Mormons, like they say in my State, or something like that. But I think if you ever went to those States, as you all point out, they are laboratories, and there are things to learn from the States about what works and what does

not work.

What does not work nationally-and Mr. Chairman, you made this point-what does not work nationally is the disincentives in the system that reward people just for doing more and getting paid for it. We have a dysfunctional market in medicine, and I think we all know that. And if you look at the differences from one State to another, you will find out that some States are trying to resist that trend, and some States are trying to do primary care over other things; some States are trying to do it right the first time, and a lot of other things; and people in other States are not necessarily

trying to do that. What States, as Senator Metzenbaum pointed out, are not doing

is they are really not doing much about health insurance regulation or anything else. They have perpetuated an insurance system which in effect has contributed to all of these problems. State legislatures are notorious for bowing to every special interest that comes along and adding to the cost of health care by adding some mandate to the benefit package. They do not do anything about the price, and they do not do anything about the product. In fact. States have been the place at which we have perpetuated this notion that everything is free, nobody has to pay for it, and so forth.

States have a lot of other problems. Medical education is becoming a problem for States as we begin to wrestle with that problem and the markets become more competitive. And in a really competitive marketplace, if you do better, you are rewarded with more business, not with higher prices. John can prove that in Hawaii, and you can prove that in Utah. That is an important fact-if you do better, you get more business, not higher prices. So when the prices go down, it gets more difficult to do medical education because so much of it is done off of clinical costs. So States have a real concern about medical education.

I guess in terms of a question, it gets to the heart—and Ms. Buell, I think you touched on it—of this issue of what comes first do we do system reform and get the costs under control first, or do we do universal coverage first. I would like to believe you can do them sort of synonymously. But unless you put your concentration on system reform and do not defeat the system reform with your apparatus for coverage, you are not going to get the job done.

So it is critical-and maybe Governor Waihee, you can help us understand how it is in Hawaii-I understood you to say that it is because of the employer mandate and because of universal coverage that you have lower costs and higher quality and so forth. I would just like you to sort of prove that. I think that is probably

a contributing factor.

But when we get around to reform, the critical issue we need to hear from you on, as I think we did in the Resolution from the Governors' Association, is there is a lot of change going on all over the place at the local level, and in Hawaii, they are out ahead of a lot of the rest-a lot of change going on. What you really need is a sense of direction, and you need that at the national level. But it is critical to understand that that sense of direction has to come on system reform, so we are getting better products, fewer of them, because many of them are not necessary, for a lower price, and then coverage reform.

I would like to hear the Governors tell us to change the way we do access to low-income—we are getting sick and tired of that Medicaid approach, because it is wasteful—and raise the money from real money that subsidizes the access for the low-income. We are sick and tired of the Federal Government and the Government in general not paying its own way on public subsidies. We are not doing the job we should on Medicaid subsidies. We are not doing the job we should on Medicaid subsidies. When you think about cost-shifting, think about that, and ask yourself are you confident that we are going to do that kind of a job.

So I would just like to hear a little feedback from each of you,

So I would just like to hear a little feedback from each of you, and not positing this issue so much on what comes first, because I think we have got to do both. We have got to do the system reform, the insurance reform, and we have got to get the universal coverage. But somebody needs to tell us, to get to universal coverage, change the way you are subsidizing the low-income, change the way we are subsidizing access for the elderly and disabled to this system, change the way you waste the tax subsidy on thousand-dollar health plans that nobody needs, just because somebody

made a promise 20 years ago.

Governor Waihee. Senator, if I may, let me begin by saying first of all I agree with you, and despite the positive things I may say about the Hawaiian experience, I will also have to acknowledge that we could have done a lot more in terms of cost containment and effective delivery of health care services. But I think the strength of our system is that it has been able to produce as much as it has, given the fact that we did not have the opportunity to do as much as we might have.

One reason why we were not able to do as much as we might have been able to is the fact that our ERISA exemption throws our system into the 1974 mode, and so I cannot amend the underlying health care system to update it as we demonstrate better ways of doing things. And I guess that underscores the States' request for

flexibility with ERISA laws.

The second reason that we have not in the past regulated insurance providers as well as we might have had to do with the fact that Hawaii was very fortunate in, for a great deal of the 20-year period, having two nonprofit insurance entities that provided about 95 percent of our health care insurance. In fact, they have been one of the strengths of our system.

As we approach the middle 1990's, though, and we see more competition coming onboard, I would like to inform the Senators that right now, I have a bill before our legislature to bring health care insurance companies under the direct regulation of the State and

to pay more attention to their internal matters.

Having said all of that, though, I do agree most forcefully with the concept that the delivery of health care services that are Government-assisted can in fact be done much more cost-effectively and better in the future. Indeed, Hawaii was able to get a waiver from HCFA this year, and we will be beginning on July 1st a new program called Project QUEST, which combines our AFDC/Medicaid programs together with some of our State Government assistance programs into a new approach to delivery of Government-assisted health care whereby, instead of direct-paying providers, we

have gone out and provided private insurance for all of these beneficiaries.

As a result of this experience, we are now able to cover people with health insurance up to 300 percent of poverty, with a copayment feature after the 100 percent of poverty level is reached. So we have done this with existing resources, and we have done it by providing the best benefit package available from all plans, and there was no cutback in Government services to do that.

We estimate that not only will we be able to demonstrate the ability to deliver more services, but we will also do it more cost-effectively. Our projections are that in the future, we will be able to return \$5 million over the next 5 years to Medicaid, as opposed to constantly asking for another \$10 million or \$20 million a year

in Medicaid increases. So you can do it.

In the area of long-term care, the emphasis in the long-term program is heavily biased to institutional care. Most of the senior citizens I know want to remain as independent as possible for as long as possible. So I have a project before our State legislature called Project Family Hope that would develop, again, a privatized approach to health care insurance that will emphasize community-based care.

We think those provisions of the health care amendment would be very beneficial in being cost-effective. So there are definitely

ways.

Finally, Senator, I think that while you may find some differences between Utah and myself in how we fund the health care system—and I have my own personal opinions about the effectiveness of Governor Leavitt's system if we were to apply it to my State, and he has his own opinions about the employer mandate—let me say that we have some very basic common characteristics, and they have to do with insurance reform and how that is approached, with the emphasis on cost containment and a number of other areas, much of which the Governors all agree on.

Ms. BUELL. Can I just make a comment, and Senator, I certainly do not want to be confrontational when you attack State legislators, but I do have to respond in terms of your characterization that State legislatures and legislators succumb to special interests.

If you look at the States that have taken aggressive health care reform measures, it has all been passed by State legislators. And believe me, in Massachusetts, we have taken very aggressive steps in health care reform. We voted on an employer mandate. I have the scars to prove that we stood up to special interest groups. So there are 13 or 14, your State among the leaders, Senator, in terms of State legislatures which have taken very dramatic action to work against some special interest groups in order to pass comprehensive reform.

So I believe that we do have the internal fortitude to deal with

special interests.

Also, in terms of the fact that we have passed every possible benefit mandate, let me say that some of our response with regard to mandates has been to react to Federal mandates that have been passed by Congress and that have been delivered to the States, and therefore we have had to respond to them, especially in the area of Medicaid.

But I do agree with you in your comments on universal coverage. The reason that I emphasized it so much is because of my concern over the past several weeks in the debate, that somehow universal coverage was losing its importance as a double track with systems reform. I believe absolutely that you cannot reform a system if you do not have everybody under it. You may do patchwork reform in a system, but once you bring in other populations that are heretofore uncovered, the system is going to have to change. So I believe with you that they have to run parallel, but my emphasis was to try to get that back in terms of the national debate.

And finally, with regard to low-income populations and Medicaid, Massachusetts has a very aggressive Medicaid managed care program, and our increase over the last year is 5 percent in terms of cost increase. It is no longer the budget buster in our budget, and it is because it was a legislative initiative to do that managed care

that has been carried out at our State level.

Senator DURENBERGER. I appreciate your comments. When I talked about history—I would not deny the fact that there are five or six States that are trying to take on this issue—but the history is that we would not have had this problem had the States not in the past been so willing to pass on the costs of health care to the private sector, to the private insurance system, to employers, and so forth.

The second point I would like to make is that if employers had not reacted against that at some point in time, I doubt if it would have stopped. And we are going to hear in the next panel from some employers who took it into their own hands to try to change this system. If we had not had the ERISA preemption to protect them from the easy way out at the legislative level, I doubt if you would have seen some of those changes. I am just speaking from my own State, and I know that in your battles there, you have worked with employers as well, and you know that they are a key to this.

But I have got to tell you that if it had not been for employers, with their employees, trying to change the system and make it work better, I doubt we would have this sort of reform effort going

on. I can tell from your basic response that that it true.

Mr. Chairman, I agree with what you said as you were leaving the room about the ERISA waiver and so forth. I want to interpret what the Governor said and what Ms. Buell said on behalf of NCSL, to say that if you do not do smoothing this year at the national level, to give us some sense of direction, then Governors are going to come back and ask for the ERISA changes and some of these other things so that we can take it over.

Whether they really want that to happen or not, you would have to ask 50 Governors and 50 State legislatures, but I think we need to interpret it as a challenge that now is the time for us to act, or we are going to get more of this kind of State by State, each one trying to do it their own way, and none of them can afford to do

it the way it ought to get done.

Senator METZENBAUM. I could not agree more with my friend from Minnesota that we have got to act. The question is how we act. And I think the Governors are saying they want more State responsibility. And frankly, I have mixed emotions about that, be-

cause generally speaking, you would accept that concept; but when I look at some of the failures on the part of the States to do that which should have been done in the past in the area of regulation

of health and the health industry, it is abominable.

West Virginia had a problem with Blue Cross, and they did nothing to protect the financial condition of West Virginia Blue Cross. They failed in 1990, leaving 50,000 policy holders with \$40 million in unpaid claims. Maryland, a very progressive State, failed to detect financial weaknesses in Blue Cross because of weaknesses in their financial reporting requirements. The Maryland insurance commissioner was obviously too close to the Blue Cross, socializing, and they failed to meet their responsibility. Even New York, which has a good insurance department, failed to detect financial irregularities in Empire Blue Cross and Blue Shield. Senator Nunn's investigation in his subcommittee found that there was gross mismanagement, wasteful expenditures and fraud by its board of directors that led to losses of \$440 million in 2 years.

Now we have the NAIC, the National Association of Insurance Commissioners, coming now with great pronouncements, and frankly, some of their pronouncements are very good, and I have worked closely with them. But then the States fail to implement those model bills. Nineteen States have not adopted NAIC's model regulation for identifying insurers in hazardous financial condition. Sixteen States have not adopted NAIC's model minimum reserve standards for insurance. I could give you a host of other areas where the States are failing to meet their responsibilities on as-

sumption insurance, on reinsurance.

The GAO found that States only spent about 24 percent of their insurance department budgets on health insurance, varying from 4 percent to 50 percent in different States. they also found that 9 States have fewer than 10 staff regulating health insurance; 19 States have fewer than 20, and 22 States do not know how many staff oversee health insurance. Fourteen States do not even have any actuaries on their staff or under contract. And in 1991, over 340,000 complaints were filed, 40 percent of them over health in-

surance.

So I have to say to the Governors' Association that I understand why you are saying that you want more of the action and more involvement. Generally speaking, I think most of us, politically, would feel that is the right thing to do. But I think I have found over the period going back almost 50 years that State insurance commissioners, superintendents or whatever they are called have generally speaking been too close to the insurance industry. Either the commissioner or the superintendent or whatever his or her title happened to be either came from the insurance industry or intended to go into the insurance industry. So I think we have an understandable wariness about trusting the States to do their job. Some will do a good job, some maybe not so good.

Governor Leavitt?

Governor LEAVITT. Thank you, Senator.

I would like to respond in part to what you have suggested and also Senator Durenberger. May I just tell you by way of background, I have been in Government for 1 year now. I came from the private sector. And much of this, I find less productive than

what I would like; I would like to get on with fixing this problem

as opposed to determining who in fact did what in the past.

I have had personal experience in the industry you speak of, and frankly, I will be the first one to tell you there are some serious limits to the capacities of State regulating in certain parts of it. On the other hand, you have to ask the question, would we improve it a great deal if we were to use the "one size fits all" mechanism for the Federal Government, and I am not sure we would.

But that is not the debate, from my standpoint. The question is how do we go about fixing this. And I have found some problems trying to now step up and deal with it, and I am finding that my colleagues as Governors have the same problems. We do need action. We need action this year. And there are a lot of things on

which we can agree that we need action on.

I have a State legislature, as we meet, back working on a health care plan in my State, and frankly, we need some tools to solve

these problems.

You mentioned insurance reform. I think legislatures around this country are now prepared to step up and enact State insurance reforms. I think we are prepared to accept, according to our own statement, minimum standards on those reforms. That is a big statement for Governors, and we are prepared to step forward and

get it done.

But there are problems. My own health plan, Senator, that I have in my own company was an ERISA-based plan, for the very reasons that you talked about. But there are limitations that I now find in dealing with this thing as Governor. I would like to fix it so that no one could discriminate against a person on the basis of a pre-existing condition. I have prepared legislation, and I believe my legislature will act this year. But I cannot do that on roughly 70 percent of the plans in my State, because they would ignore me and say, "We are ERISA." I cannot solve that problem.

I would like to be able to assure that no one can cancel a policy in my State for any reason other than not paying the premium. But I cannot do that on 70 percent of the folks in my State, because they are regulated under an ERISA plan, and they ignore me—

when I say "me," I mean the State.

I would like to be able to narrow the means by which people can make decisions to underwriting, to where they cannot ultimately—they ultimately cannot not issue a policy because of medical underwriting conditions. But I cannot do that on 70 percent of the people who do business in my State because they are regulated by a different mechanism.

I have got a terrific plan, I believe, and my legislature and my communities have come together. And interestingly enough, I now have the support of the insurance industry and the manufacturers and the doctors and the lawyers and the hospitals. We have all come together on this plan, but we cannot implement the plan in a lot of respects, because we need some tools, and we need the Congress to help us act.

We are planning the development of a cooperative that would make it possible for individuals in my State and the small businesses to have the exact same buying advantages that are available to some ERISA plans. But I cannot do that because I have got

to have some tools and some flexibility.

I am as frustrated as you are, Senator, about the nature of Medicaid. It does not make sense to me. Early on in my time as Governor, I went out to one of our human services areas, and I sat down with one of the caseworkers. She had a stack of files about this big, and we worked through them, and I picked up one of the files, and she said, "Oh, I remember this women. This is a woman in her early 30's. She has three children. She came to us without a job, and we gave her AFDC—as I remember, it was \$419.02 a month with her situation—and we provided her with Medicaid. Well, she got a job that paid her \$5 an hour. And she did not have health benefits, but we were able to supply her with health benefits for that period of time, for a year. Now she is back in my stack because 11 months and 15 days have passed, and she found that in her job, she would not have the capacity to continue her health benefits. So she did the only thing she thought she could do, and that was to quit her job."

Now, that does not make any sense to me. I said to the caseworker, "I am a smart guy from the private sector. Why don't we just do something that makes sense? Let us just take part of the money we would be paying for AFDC and just pay it for health

benefits."

She said, "That would be a smart idea, but we cannot do that be-

cause we have some Federal regulations that prohibit it."

Now, I come into this thing fresh, not having dealt with what happened in the past, and I am trying to deal with it and what is going on in the future, and I do not find the tools there available to do it. But I think if you will give us tools, if you will give us timetables, if you will give us some flexible frameworks, we will all find our own solutions.

John and I were just going over some health statistics from our mutual States, and we approach health care in dramatically different ways—but you know, we are next to each other in many of these categories. Here is one—percentage of the average family income spent on health care. I am 43rd and he is 44th. There is two-tenths of one percent difference. He has a radically different plan

than we do, but he has different situations than we do.

Now, Senators, we are prepared to take this on, but we do need action, and we need it this year. We need tools. We are prepared to move forward and play our role in this process. We each have a role—we have a role, you have a role. It is clear to me that we cannot solve this without having the capacity at some level to deal with your income transfer capability; we do not have that ability, and we will. But we need tools, and we need them now.

Senator METZENBAUM. Thank you very much.

Governor WAIHEE. Mr. Chairman, if I may just add something briefly to that and say that unlike Governor Leavitt, I have been at this, and I am now at the end of my term, so I have been dealing

with Government for about 7 years.

Let me say that when we testify on this issue, we have emphasized the need for State flexibility. However, you ought to know that we are also doing it with the assumption that there ought to be a Federal scheme. I mean, more than conceding, Governors are

encouraging the development of a Federal scheme for health care for our Nation. We would just like to testify that within that scheme, we have the flexibility to work out some of the problem

areas that we have noticed in prior partnerships.

We know, for example, that if this is going to work, there needs to be national health care insurance reform to ensure the portability of health care plans between States. We know that if this is going to work, there has to be, or should be, a basic benefits or core benefits package so that we can all be on the same playing

We know that there is going to be a need for tax treatment of

premiums to be uniform and reflect this kind of national plan.

So we do realize and are essentially testifying for flexibility within the context of an overall call for action, and we appreciate your sensitivity to that point.

Thank you.

Senator METZENBAUM. Thank you, Governor Leavitt.

Senator Wellstone?

Senator WELLSTONE. Thank you, Mr. Chairman.

First of all, let me apologize. This is deja vu for me. When I used to come up here and testify once in a while, I used to get so annoyed that people were in and out and did not seem to be paying attention-and that is exactly what I have done while you have been testifying. And it is only because of some conflicts all about health care, so I really apologize for my impoliteness of going in and out and not being here to listen to what you had to say.

Hey, I am Jewish, and I feel very guilty about this. [Laughter.] I really apologize to you, and I have some questions that I would like to send to you in writing. I do not want to take any time, Mr. Chairman, because we are way behind now, and I know we want

to get to other panelists as well.

Thank you for being here, and we will talk.

Senator METZENBAUM. Do not feel bad, Governor Waihee. I have checked with the committee, and we have decided to have the next field hearing in Hawaii. [Laughter.]
Governor WAIHEE. Thank you. We would be glad to welcome you

and to host you.

Senator METZENBAUM. Thank you very much, all of you.

I will turn the meeting over to Senator Wellstone. I am due at

another matter shortly.

Senator Wellstone [presiding]. Our next witness is Ken Thorpe. Mr. Thorpe is the deputy assistant secretary for planning and evaluation at the Department of Health and Human Services, and he has agreed to share with the committee some new estimates on how much the States stand to save under the Health Security Act.

Mr. Thorpe, we look forward to your testimony, and I am full of apologies today. I apologize for the delay. We had votes, and we are

little behind.

Please proceed.

STATEMENT OF KENNETH THORPE, DEPUTY ASSISTANT SEC-RETARY FOR PLANNING AND EVALUATION, U.S. DEPART-MENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. THORPE. Thank you, Mr. Chairman.

I am pleased to be here to report on a very recently completed administration analysis of the Health Security Act and its impact on States. I am going to summarize my remarks, but I would ask if we could submit a copy of the analysis for the record.

Senator Wellstone. It will be in the record.

[Document referred to may be found in the appendix.]

Mr. THORPE. States, like the Federal Government, business, and families, face very similar and mounting problems with the health care system, in particular, the high and rising costs of medical care. Certainly from the State perspective, Medicaid in many States, if not all States, is a real budget buster.

Since 1980, Medicaid costs have risen about 440 percent, so that now, the projections out are that Medicaid will comprise about 25 percent of States' budgets. That is up from just 17 percent in 1992. So Medicaid is a very special problem from a State budget stand-

point.

The uninsured, we know that States and localities spend a substantial amount of money covering individuals who are uninsured in their States, and the rising number of uninsured that we continue to see places increasing strains on State budgets as well as localities.

Now, we believe that the Health Security Act focuses on addressing many of these issues, and in particular the proposals for universal coverage and cost control of both the public and private sectors, we think directly address these issues not only at the State level, but at the national level as well.

Having said that, let me briefly summarize what we see the fis-

cal impact to be on the States with the Health Security Act.

First of all, we believe that there will be a very positive and substantial positive impact on State budgets with the Health Security Act. Our estimates show that between 1996 and the year 2000, States would save at least \$53.6 billion during that time period.

Let me briefly summarize the areas where States are likely to save. First, with respect to Medicaid, under the President's plan, Medicaid beneficiaries will be allowed for the first time to be mainstreamed into the system and to purchase private health insurance. From the States' standpoint, what they have to contribute on their behalf will grow at a slower and very predictable rate. For anybody who has dealt with State budgets, those are novel. The Medicaid spending growth in States is legion for its unpredictability; they are not unpredictable with respect to their high growth.

On the Medicaid side, we are estimating that States would save \$40.3 billion due to the fact that what they have to contribute on behalf of their Medicaid beneficiaries for health insurance coverage will grow at a substantially slower rate than it otherwise would.

A second area of savings is dealing with the home and community-based care programs. We are estimating that States could save up to \$7 billion between 1996 and the year 2000 under the President home and community-based care program. As you remember, the home and community-based care program allows States to provide services to existing severely disabled who are being cared for under existing Medicaid programs, as well as those individuals

cared for through the State-only payments that many, many States

provide services to severely disabled individuals for.

Due to the more favorable match in this program—that is, States would be expected to contribute only between 5 and 22 percent of the cost of providing services to the severely disabled in this new program—it will allow States to substitute existing Medicaid dollars, as well as existing dollars they are spending on their State-only programs, moving some of those dollars into the new home and community-based care program, allowing them to save money on those populations, while at the same time expanding services to populations that currently are not receiving services through existing programs.

We think this not only is a good program in terms of expansion of services, but in terms of refinancing existing State obligations for providing care to those populations, we think it will also provide

substantial fiscal relief.

The final two areas that have, we believe, a direct impact on State budgets have to do with savings that States would face for their active work force. States, like other employers, are likely to save substantial amounts of dollars on behalf of their active work force, again because of the fact that the cost containment provisions in the President's plan would allow States to make contributions for health insurance for their workers and have those contributions rise at a slower rate than has been projected.

In the year 2000 alone, we projected that States would save \$5.6 billion on their active work force and, due to the early retiree components of the President's plan where States would no longer have to pay the 80 percent share of the premium on behalf of their early retirees, in the year 2000 alone, we are projecting about \$700 mil-

lion in savings.

So the sum of those four comprises our estimate of about \$53.6

billion in savings to State Governments.

In addition, I should point out that there are several other aspects of the plan that will have an important impact on States and State residents. First, there is a substantial amount of support for State residents and business to purchase health insurance under the Health Security Act. In particular the discounts that apply to residents and to firms in those States, we are projecting that in the year 2000, there would be an \$81 billion increase in Federal funding flowing into the States to help support the purchase of health insurance for State residents.

Another area that is important to point out has to do with the new public health initiatives. There will be a net increase in spending in public funding to provide support for community health centers and manpower initiatives in States, and that net increase in

public funding will be about \$5.6 billion.

Finally, I think it is important to point out that employers in the States will save overall—and this includes all employers, including those that do not currently provide health insurance today—about \$27 billion in premium payments. Now, that becomes important because in the States, that is likely to create a more favorable business climate, allowing firms and employers to take those savings and reinvest them in increased wages or retain them as higher

profits, which from a State budget standpoint becomes important because it is likely to increase tax receipts flowing into the State.

In conclusion, we believe that, as it does for the Federal Government, businesses and families, providing universal coverage, coupled with controlling the growth in health care costs, that the Health Security Act is going to provide a very positive fiscal impact on States, as well as promoting the health of all Americans.

That is just a quick summary of our results, Mr. Chairman, and I would be happy to answer any questions on the analysis or find-

ings that you may have.

Senator WELLSTONE. Thank you, Mr. Thorpe.

I think if it is okay with my colleague, Senator Durenberger, we will try to limit our time to 5 minutes each so that we can move along and do not run out of time for other panelists. Is that agreeable with you, Senator Durenberger?

Senator DURENBERGER, Yes.

Senator WELLSTONE. First of all, let me applaud your emphasis on universal coverage, because I think that that is part and parcel of cost containment.

Second, let me applaud the language in the proposed legislation that does give States flexibility to opt for single-payer—I am a strong single-payer supporter—but also deals with the ERISA problem in a way that I think is helpful to other Governors who want to move in other ways.

Can States expect to see the same savings under other bills as the private insurance system to expand access and control costs? In other words, other plans reduce the Federal Medicaid spending, but they do not have similar limits on State Medicaid costs. It

strikes me that that is an important distinction.

Mr. THORPE. Well, we have not done specific analysis of other proposals, although my strong sense is there are two major reasons why States sa well as the Federal Government have such a positive fiscal impact. One is that universal coverage is, I think, the key piece of this because States today provide a substantial amount of financial support to provide care for individuals who do not have health insurance. So without universal coverage, the fiscal impact on States is not going to be as positive as what I have reported.

Second, also a critical piece is the cost containment aspect of this that not only applies to the Federal share of Medicaid, but also applies to the States piece of Medicaid. And again in particular, the fact that States would have to make contributions on behalf of their existing Medicaid beneficiaries and have those contributions grow at a much slower rate than they are today, which is outlined in the legislation, is very critical, I think.

So both of those components of the Health Security Act lead to a very positive fiscal climate in States. To the extent that other proposals do not have either of those components in them, then the fiscal impact would not be as favorable.

Senator Wellstone. Nor do they have, excluding single-payer,

any Federal subsidies for retirees-Mr. THORPE. That is exactly right.

Senator Wellstone. Since I said we would limit our time, and we want to go over your data more carefully, let me flag for you one concern that I have that I will be conveying to the White House, and I think it directly impacts on this whole issue of cost

savings. It has to do with the issue of opt-out.

There has been discussion this past week, and I know Secretary Bentsen has suggested that as opposed to 5,000 employees, maybe opt-out could reach down to businesses with 100 or 200 employees, or more. My concern is this. I think that if we do that, there will be multiple opportunities for some of the cherry-picking and discrimination that we have seen in the past. That is to say, we do not really know what hiring or firing decisions are based upon whether someone's daughter has diabetes, and moreover, with the sort of flexibility of what companies can do vis-a-vis their own premiums, we can also see a tremendous amount of charge-shifting back and forth.

Moreover—and this is right up your alley—we have yet to be able to get a very firm estimate as to how many employees that would really be and what impact that would have on the alliances.

So to my own way of thinking, and the reason I raise this question with you, I think that what would happen is it would become so fragmented, with so many opportunities for cherry-picking, for risk selection and for charge-shifting, that if we either just let that go or we set up a system of strong community rating across-theboard, or we will have to set up a bureaucracy to monitor this to the point where the bureaucracy we have to set up will undercut the very cost savings we say we are trying to effect.

I do not know whether you want to respond to this today, but it strikes me that this has real implications; this proposal that the opt-out would go from 5,000 to 100 or 200 has, I think, a serious

impact on your estimates on cost savings.

I would just like to get your quick response.

Mr. THORPE. I think you have made a very compelling case for larger purchasing alliances as opposed to smaller ones, and I would not disagree at all with that. Certainly, there is a considerable amount of discussion surrounding the size of the alliances, and I think you have pointed out the appropriate trade-offs. And I know in the coming weeks, we will work very closely with you and the committee on thinking through what those trade-offs are and thinking through what the most appropriate size of the alliance would be.

Senator WELLSTONE. I will now hand this over to Senator Durenberger, but since you are today representing the administration, I would like for you to know that I believe that that proposal, as I understand what Secretary Bentsen said, is profoundly mistaken and, I think, will have a huge and negative impact on the very goals that you have stated, or the goals of health care reform.

Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, thank you.

I am not Jewish, but I do join in the apologies, particularly to Bob Waller and to Steve Wetzell and Rick Curtis and the other people who just got delayed by 15 minutes because the administration decided this was a good time and a good place to do their PR.

I admire you, Ken, and I admire the work that the administration is doing, but I do not like the idea that this is the place that was chosen to do that. I have said that to the staff and to the chairman, and I will just say it publicly now.

I have been doing health care reform since I got here. We did health care cost containment with Jimmy Carter. We have done DRGs, RBRVSs, outcomes-based work, Medicare catastrophic, and I have done it with the Mitchells and the Baucuses and everybody, and it has been very, very bipartisan. I did small group insurance reform in 1990, and we still have not gotten it through here, even though Lloyd Bentsen and I both tried to do it.

I figure I get paid to get things done, not to get the credit for

them, education programs.

I do not like the idea that as we speak, the White House is working its way through the Business Roundtable again, asking them not to endorse a part of their own bill, which is the managed competition part of their own bill. It is like we are in a big fight of

some kind around here, and I really do not think we are.

So I guess, speaking as a middle-of-the-roader-and old Gene McCarthy used to say that is always the toughest place to be, because that is where the most accidents happen-but I must say there is a frustration with trying to do a good job, trying to find the answer, trying to find the middle, and that is one of the things this hearing was designed to do with regard to the States and so forth—and I know this relates to the States and so on, but I cannot ask Ken Thorpe intelligent questions. I can pretend that I can, but we did not even hear about the report until yesterday afternoon. I would not argue with his results any more than I would argue, Ken, with the results from the overall estimating. I would argue with your presumptions. Your presumptions are fallacious on the universal coverage. You say there is no cost-shifting; yet you build cost-shifting into the law by shifting the inadequacies of public subsidies onto employers, and then presume that we will stick to our guns once we have done that and that we will capture all these savings and we will do all these sorts of things.

But that is a debate that I would like to haking about. We prefer that these occur mostly at the Federal level because of the uniform-

ity that can be brought by the Federal system.

We favor a number of things, but let me give you the top six or so—basic coverage for all; help for low-income citizens; insurance reform, which has been discussed in detail this morning. The real costs are in the utilization of care, and we strongly favor practice analysis, looking at what we do for our patients, with a goal of eliminating unnecessary care, but also encouraging necessary care.

We strongly favor limiting tax deductibility of health benefits to the cost of the standard benefit package, perhaps for other reasons than have been discussed today and at other times, to minimize

overconsumption.

We favor nonregulatory purchasing pools, and we favor adminis-

trative reform.

What are the concerns relative to the State activities? It was said earlier this morning that much medical care is local, but much medical care is not local. Twenty-eight percent of the physician care given in the State of Minnesota is for patients who live in other States. Twelve percent of Minnesotans receive their care outside of the State of Minnesota. If you look at the data in our written testimony, I think you will see that crossing State borders to receive medical care is common throughout this country.

And I would just say that if there is one thing to remember from us, it is that when patients are sick, and when they are really sick, the last thing on their minds is a county or a State line; that is not important to the patients when they are sick.

So we come at this by just raising the red flag—the potholes, as I think someone said earlier—about creating barriers for patients who seek care outside their home States or local areas. And I will

just mention very quickly five potholes.

The global budget for the State will result in protectionist policies and keep the budget at home. Second, alliances, given regulatory authority, will do the same thing. Third, if every State or every alliance sets the fees, any medical center that sees patients from around the country as we do—and there are many across this country—will be dealing with a minimum of 50, or perhaps several hundred, regulatory bodies. Fourth, if every State decides on what the practice guidelines should be and how we should set the rules for data collection, we will be in an impossible situation in our institution and others like us. And fifth, I would just mention that we have the largest training program in America. We train approximately 1,000 physicians, anywhere from 3 to 10 years after they finish medical school. Eighty percent of them leave the State of Minnesota and go elsewhere to practice.

So I would just make the point that our educational needs and our research needs are nationally based. We serve the national needs in research and education, and we have a concern that if our States become more involved in a piecemeal basis, we will have 50 different programs for our research and education activities. Na-

tional needs need national oversight.

So in summary, let me make three points. We favor marketbased reform. We favor the sense of direction that Senator Durenberger has talked about, and I have outlined those tools or those opportunities. We sincerely hope that States or State-created alliances will not limit interstate movement or create the administra-

tive variations to impede the working of the marketplace.

Let me just point out our view relative to Minnesota, and we can say just very quickly what we said to the leaders in the State of Minnesota. We suggested that they delay action at the State level so that the potentially unnecessary administrative activity is forestalled, given the health system reform at the Federal level which just has to happen this year, and then the Minnesota 1995 legislative session could then pass a bill to complement the Federal legislation in 1995.

So again I would just say in summary that when patients are sick, the last thing on their mind is the country or the State line, and we just hope that as reform evolves, we will not create the bar-

riers that I mentioned.

Thank you.

Senator Wellstone. Thank you, Dr. Waller, and I think, by the way, there is a pretty strong consensus among those of us who have different proposals that we not create those barriers of State lines.

[The prepared statement of Dr. Waller may be found in the appendix.]

Senator Wellstone. Mr. Wetzell?

Mr. WETZELL. Thank you, Senator.

I think Minnesota is more than adequately represented in this room this morning, and I would just like to acknowledge on behalf of the 24 employers I work for the efforts of both of our Senators. We certainly do not agree with all the views that the two Senators have, particularly Senator Wellstone's views—

Senator WELLSTONE. Then, we will ask you to excuse yourself

right now. [Laughter.]

Mr. WETZELL. But I think the common ground is you are both looking to a Federal solution to a national program, and representing multi-State purchasers, that is what we are looking for, too. So

just a little public acknowledgment.

The Business Health Care Action Group is a coalition that believes that the private sector has a positive and very influential role to play in health care reform. And before we talk about our views on Federal versus State regulation of our purchasing activities, I think it might be helpful to take a couple minutes and talk about what we are doing and how we believe it presents a model for private sector initiatives that can benefit all of society in health care reform.

We are an organization of 21 large, multi-State, self-insured employers. We provide health care benefits for more than 1.5 million Americans voluntarily, and pay for more than 70 percent of the costs of those benefits. And we are not satisfied with the products that we currently offer to our employees. Because of that frustration, we have come together in a product that is self-insured under the protection of ERISA, and we are working directly with regional health providers to improve the quality of care for the people we insure and to contain costs at the same time. We believe those two go hand-in-hand.

Some of the concepts that Dr. Waller just talked about, we agree entirely with. We are working directly with Dr. Waller's organization to define practice parameters, to set quality standards, to contain costs and make sure we are focusing our limited resources where they belong, and we are an example of purchasers and providers working directly together, without the burden of unneces-

sary State regulation.

We have agreed to a common health plan, all 21 employers. We have agreed to the same set of benefits, which are extremely comprehensive and provide very generous coverage to people who participate in our plan. It maintains the freedom of individuals to choose their physicians, but provides incentives for them to use providers that are participating in quality initiatives and that offer more cost-effective care, like the Mayo Clinic and Group Health, whom you will hear from later. And we believe we are demonstrating that we have a role to play.

Some of the results we have seen in the first year with our plan. First, it covers five States. Although our employers offer coverage in all 50 States, our product is regional at this point. It covers citizens in Wisconsin, Minnesota, Iowa, and North and South Dakota. With all the protection we currently have under ERISA, we would not have been able to of the physician care given in the State of Minnesota is for patients who live in other States. Twelve percent of Minnesotans receive their care outside of the State of Minnesota.

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Some of the results we have seen in the first year with our plan. First, it covers five States. Although our employers offer coverage in all 50 States, our product is regional at this point. It covers citizens in Wisconsin, Minnesota, Iowa, and North and South Dakota.

With all the protection we currently have under ERISA, we would not have been able to accomplish what we have in the last 2 years.

Our average cost for our product in the first year was \$2,500 per employee, with no cost-shifting to other payers. We are using the same fee schedules that other purchasers are in our market that are buying managed care products, and we have done it through a collaborative effort with our providers to reduce unnecessary utilization. I think that is a very critical message, that we feel we are improving the quality and the efficiency of providers not only for the care they offer to our employees and our retirees and their fam-

ilies, but for every patient that they see.

We have reduced the cost of care by 11 percent in the first year of our coalition product, and that is compared to other managed care products in the region. We have reduced the trend to 4 to 5 percent per year in annual cost increases, without cost-shifting to other payers. And most importantly, we are working directly with the people who matter most—the patients and the providers of care. We are working directly with the providers to define quality standards. We are measuring outcomes to make sure that we are paying attention to the ultimate measure of success—how well we are keeping people healthy and treating disease—and we are not doing it at the expense of other payers and cost-shifting through discounts, which is a problem that large employers are accused of pushing all the time.

The message that we would like to send is, first, that it is absolutely essential that the Federal Government address certain needs in the near term, and preferably this year. We recognize that if certain Federal issues are not dealt with, the States have no choice but to continue to pursue ERISA waivers, which creates a regulatory environment that will simply drive us out of the market-place. We cannot deal with 50 different sets of rules and deliver

our benefit plans cost-effectively.

So we are asking the Federal Government to move quickly and set standards, and particularly to set standards for self-insured employers that create the appropriate accountability that a lot of the

folks who have testified this morning have talked about.

Specifically, what we would like to see and what we advocate is a higher degree of accountability for our purchasing activities. We would recommend that the Government, if there are going to be standard benefit sets, that they be applied at the Federal level and

not be given to 50 different States.

We would agree that the Federal Government should engage in underwriting reform for our products as self-insured employers as well as for commercial insurers. In other words, we are willing to live by rules at the Federal level that prohibit pre-existing condition exclusions and that prohibit waiting periods for those employers who choose to offer health plans, provided that those same rules are applied to commercial insurers.

We favor stronger Federal solvency requirements for self-insured plans. If we are going to be in the business and self-insure and cover employees and their families and retirees, we should be held accountable to make sure we have adequate financial reserves to honor our promises, much like you have done with pension plans. We favor the same type of regulation on our self-insured products.

but again at the Federal level.

We believe that there is a need for data to measure quality and to benchmark patient outcomes across competing systems of care. Our fear is that each State will do its own thing, and it is going to create a nightmare for us. We strongly advocate that the Federal Government define data standards, and that they create a Federal repository, which we will gladly provide the appropriate information for, and that the Federal Government make that data available to the States so they can meet their needs-but do not subject us to 50 different States doing different things on data requirements.

We strongly advocate subsidies for low-income families. We do not agree with employer mandate. We do agree that employers and all Americans should participate in a tax base that provides sub-

sidies for low-income families.

And, while our employers voluntarily cover 1.5 million Americans, they are willing to participate in a tax base to provide subsidies for low-income Americans. We do not favor a tax base that is driven by premiums, that is driven by provider taxes, or a tax base that is driven by whether or not an employer chooses to offer a health plan. The danger is you may drive the private sector out of the market with those types of premiums or those types of tax subsidies.

So we would favor a broad-based tax subsidy that employers par-

ticipate in based on ability to pay.

We also favor general Federal regulatory requirements for voluntary private sector health alliances. We are in the process of inviting small employers into our coalition. We want to pool their risk and invite them to participate in buying with the large employers. We cannot do that currently because the State regulation in our own State makes it virtually impossible for us to create a product within our coalition for small employers because of barriers of State regulation. And we favor Federal standards for voluntary alliances for employers of all sizes.

And finally, just a couple comments on the administration's plan. One of the fears we have is that the administration does not understand the real effect of the proposal as it exists today. It will drive

the private sector out of the market.

We have 22 employers—companies like Dayton-Hudson Corporation, 3M, Cargill, General Mills, Pillsbury—and each one has taken the position that if the administration's plan passes as proposed, there are no incentives left for them to be involved in health care reform. They will pay their tax, and they will get out of the business.

I think that is a very important part of our debate—do the Congress and the administration believe that the private sector has a positive role to play in moving the market ahead and financing benefits, but keep us involved and keep us incented to contain costs and improve quality.

The bottom line is the administration's plan does not do that. It would drive us out of the market; our initiative will stop; all of our employers will pay the tax, and they will no longer be involved in

the effort to move ahead and solve this problem.

Thank you for the time. I am sure I have gone over 5 minutes. Senator Wellstone. Thank you very much. It is hard to come from afar and be immersed in this and have it be a big part of your professional life and have to limit your remarks to 5 minutes.

[The prepared statement of Mr. Wetzell may be found in the ap-

pendix.]

Senator WELLSTONE. Mr. Curtis?

Mr. CURTIS. Senator, as you indicated, while I am president of a 501(c)(3) organization that receives grant funding from foundations, I am not here on behalf of the institute; I am here as an individual. We do not take positions on Federal legislation.

Let me quickly run through some of the major issues-many of them have been raised by the previous testimony—that I would like to comment on at this hearing.

No. 1, I think it is clear we need Federal rules with respect to access and issuance of insurance, continuity of coverage benefits, and so forth, if we are going to provide protection for all Americans, and that should fundamentally be what this is all about.

As people change locations, as they change size of employer, as they go from an insured to a self-insured plan and so forth, unless we have Federal rules that are specific and uniform, people cannot

rely upon those kinds of protections.

There are other reasons for the Federal Government to do this. I mention a number of them in my testimony. Among them, if the Federal Government is supply subsidies for low-income populations-and I believe that is absolutely essential-and if it is mandating someone on some basis to finance coverage—and I think that is necessary as well, as I will get to later—the Federal Government obviously needs to worry a lot about the basis upon which the rates for health plans are established, and that says rating rules should be established at the Federal level.

On the other hand, I think the Federal Government should not be overly prescriptive with respect to geographic rating areas-I am now talking about medium and small-size employer markets as well as individual markets-or health plan service areas, although I think previous testimony has raised very real and important issues about referrals for tertiary services. And there should be protection somehow in Federal law against constraints on especially

referrals to institutions like Mayo.

On the enforcement end of it, though, I believe States are in a better position to enforce insurance market rules for insured plans simply because they have a regulatory infrastructure up. The Federal Government does not have such capacity now, nor does it have pertinent experience, and where there have clearly been problems in a number of States, arguably many of those are related to the very complex nature of the current system and the fact that there are no current guidelines.

The deputy insurance commissioner on a panel I was on at the end of last week from North Carolina mentioned that the Blue Cross/Blue Shield in North Carolina has somewhere between 22,000 and 27,000 different benefit offerings in that State. I do not know how in the world anybody is supposed to effectively regulate

that kind of a market.

While these rules are essential at the Federal level, I believe that rules alone cannot begin to fix the inefficiencies and inequities of the current small group and individual market, and I go into some of the reasons for that in the written testimony. Among them, though, as you mentioned, Senator, the opportunities for risk selection and selective marketing are monumental when you have individual-by-individual and small employer-by-small employer contracting. We have very, very high administrative costs for that kind of system, and many of the people needing subsidies fall into that market. The Federal Government needs to provide subsidies and clearly does not want to subsidize that kind of inefficiency.

In addition, there is extraordinary instability of jobs and employers in that part of the market, and place of employment simply is not for that part of the market a stable place for people to pick a

plan.

In addition, we have the problem of bringing the kind of integrated health delivery system both of the previous presenters have described to these people who can least afford less efficient forms of coverage, and we need them to be able to keep that as they frequently change jobs or change job status. And through an alliance

structure, they would be able to do that.

For all of those reasons, I believe Federal law should make this kind of structure the mandatory vehicle for coverage for that part of the market, and I would like to emphasize, for the first time for most of these people, give them much broader choice of plans than they now have. I think you will find industry trying to strike fear in the hearts of Americans on this choice issue; the simple fact of the matter is that if you work for a small employer now, and you are lucky enough to have coverage available to you, in the vast majority of cases, you only have one plan available to you. Under this structure, individual Americans will have far broader choice of plans.

An issue of concern to me is the "Catch-22" for the Federal Government of trying to make sure that we can control the impact on the Federal budget and control potential deficit problems, while providing adequate insurance, since the subsidies will be there for low-income folks. The administration's proposal, of course, has a global budget that allows both of those commitments to be made. Without commenting on my own personal feelings on the issue, I think it is clear that is one of the things that is most likely to go. If it does go, this balance between protecting the low-income people and protecting against uncontrolled Federal deficit increases is

I just want to urge you not to go in the direction of delimiting or capping Federal subsidies and putting States on the hook for the rest. There are a variety reasons why I am fearful about that, and I explain those in my written testimony. Among them is the vola-

tility of State revenue structures, testimony.

going to be very problematic for the Congress.

Finally, I do want to emphasize that, as previous testimony has indicated, I do not think we are ever going to get cost discipline in this system, let alone equity in access, unless we have universal coverage. We have a Byzantine system of cross-subsidies right now, and cost-shifting that makes it absolutely impossible to figure out who is accountable for what kind of costs. Until we fix that, I do

not think we will ever get systemic control over costs, and we will never be able to solve the problem for our economy or, as many large employers think, the problem with respect to the Federal

trade deficits.

I think only the Federal Government can achieve universal coverage. It is not only a legal problem for States, but in addition to that, if a State were to have mandatory financial participation of some sort—I do not care if it broad-based, or employer financing mandates, or individual mandates—in any event, a State with a large population contiguous to the borders of other States simply is not in the position to do that, because it will lose jobs and people and employers to the contiguous States. So the Federal Government has to bite that bullet.

Thank you.

Senator WELLSTONE. Thank you for your fine testimony.

[The prepared statement of Mr. Curtis may be found in the appendix.]

Senator Wellstone. Dr. Pearson?

Dr. PEARSON. Thank you very much, Senator, for having me here

to testify. I will get right into it.

I am here today speaking as a physician, as co-chair of the Minnesota Chapter of Physicians for a National Health Program, and on behalf of the Health Care Campaign of Minnesota, a coalition of 33 Minnesota organizations.

I am a physician in Minneapolis, employed in a staff-model HMO, and I believe HMOs have a place in a reformed health care system. However, in my rly-planed health care for the State, which resulted in escalating give the State and Federal Governments authority to eliminate waste, control costs, and help to intelligently

plan our health care future.

Proponents of managed competition have touted Minnesota's health care system as less costly, with higher quality, than the Nation at-large, and give credit to competition in HMOs for these presumed facts. Strong evidence suggests these assertions are false.sed reform, and try not to combine the market with the regulatory m the late 1980's found Minnesota health care costs above the national average and health care inflation equal to the national average despite high HMO penetration.

This is not surprising considering the U.S. GAO just released a study showing "no conclusive evidence exists that HMOs save

money."

With passage of HealthRight in 1992 and MinnesotaCare in 1993, it appears there has been an improvement in costs in Minnesota; but I assert that this is due to thoughtful planning by the State Government and spending limits imposed by the State.

My personal experience and colleagues' experience is that strong pressure to begin implementing strict cost saving interventions in HMOs clearly came as the deadline of spending limits imposed by

the State approached.

Quality in HMO and non-HMO systems in Minnesota is good, but with the new spending limits combined with the inability of HMO competition to save money in other areas, there has been pressure to reduce spending on direct patient care. Physicians are continually being asked to see more patients in shorter time peri-

ods, and other providers are being pushed to increase patient volume by up to 50 percent. Ten to 20 percent of the patients I and my colleagues see each day report their doctor has left our HMO, or they do not have their own primary care doctor, or their insurance plan changed providers, forcing them to leave the care of their long-term, trusted doctor.

This is poor continuity of care. There may be short-term savings by this approach, but patient care will likely suffer in the long run.

Another disturbing feature of Minnesota's health care system is the enormous concentration of power that three big health plan companies have acquired in the last 2 years. Within this framework, and because of too little State regulation in MinnesotaCare, it is probable that three large Minneapolis health care corporations will either, on their own or in joint ventures with a few regional powers, will dominate rural Minnesota's health care system within 2 years.

Corporate CEOs in Minneapolis will dominate the health care decisions of rural Minnesota. MinnesotaCare gives us another example of why we cannot rely on free market competition in health care. There is no incentive in the marketplace to enroll high-cost Medicaid patients in HMOs or other private sector providers.

Traditionally, Minnesota's HMOs have had healthy, employed enrollees and a very low percentage of Medicaid enrollees. This was inefficient, poorly-planed health care for the State, which resulted in escalating ot sure their philosophy is the Mayo Clinic's philosophy, and I am not sure they are going to be doing the same visa-vis delivery of services. I know the way you do it, and that is to me an important question.

Dr. WALLER. There are many—we are just one example—there are many others of integrated health delivery systems which we think if you add the integration of the system, plus market-based reform, and try not to combine the market with the regulatory

model, I think that is where our best chance lies.

Senator WELLSTONE. I am going to have to leave, but Steve, if it is okay, I would want to talk to you about something that Glenn had mentioned, and that is, I am interested in—the figures you give on what it cost to cover, per covered life, per covered person, are low—and I would be more interested in how you do that. There is a question whether there is charge-shift, and you say there is not. I was listening to Dr. Pearson's analysis and then your analysis, and at some point in time, I would like to talk with the two of you more about it.

I really thank you for coming. I am going to have to excuse myself to all of you. Thanks for taking the time to come. We will make

sure that our colleagues look at the testimony as well.

Thank you.

Senator DURENBERGER [presiding]. I promise not to keep you much longer. The difficulty I have found in a lot of these hearings and the debate and so forth is that we all use the same words, but we usually speak a different language. One of those is choice of docs.

I met with a group of Minnesota nurses a couple weeks ago, and they were on this same issue of choice, and one of them piped up and said, "Well, you know, what we are really concerned about is continuity"—this notion that the doctor is the key to the system is not really what people are looking for. They want some continuity. They want to know that there is a consistency in the relationship between them, as we as people, and the providers in the system.

That is just one example of the language problems we seem to get into. HMOs is another one. It is as though an HMO is an HMO is an HMO. I agree with the point that you were making, Dr. Waller, that the key is in the integration of the services, and that is what HMOs do well, some of them do it less well, as do other integrated organizations.

But a very important part, if you look at the results from a Mayo Clinic or some other similar system where the service delivery system is integrated, and there is some relationship between what goes in and what comes out and what the price is, is that you define quality differently from the way we usually define the word "quality." Many of us think about quality as one of those licensured systems where all the folks in this category do such-and-such, or we mean that you always have some kind of result which we cannot put our finger on. But if I understand quality as I watch it practiced in integrated systems, it really is that you get it right the first time; the resource combination says we are going to get it right the first time, we are going to see that everything that needs to be done, actually gets done. Then we are willing to take responsibility for the result, for the outcome.

You can comment on this yourself, but it seems to me that this is what Mayo and Mayo-like integrated systems have been doing for a long time, and the relationship, then, between your overall costs and what you do is pretty good. And yet the reimbursement systems and the rest of the national system do not seem to put a

value on it.

Uwe Reinhardt's Christmas card this year says that every time a Florida doctor wants to take a vacation, he just sees more patients. And the way the Medicare system works, that means that a Duluth doctor cannot go skiing because this is the way the Federal Government reimburses; you know, in one part of the country, they just let the thing go up, and they penalize another part of the country for the consequences. But there is very little in the reimbursement system, and Medicare and Medicaid are examples, that currently rewards your definition of quality.

Maybe you could just comment on that a little bit.

Dr. Waller. A couple comments, Senator Durenberger. It is interesting to us that the rate of growth of our health care costs in our own organization let us say from 1982 to 1988 grew at a rate of about 8.5 percent per year, which was pretty close to the national rate of growth of health care costs; but in 1987, we began to peel away, and our average is down more in that 3.5 percent range.

It is of interest to us that 1986 was the year that we integrated with our hospitals in Rochester. Now, since then, we have closed one emergency room, we have closed a catheterization laboratory; we have tried to make every effort to not duplicate services. And that is good evidence to us that integrated systems like ours or any others that are out there developing now—that is some good news

about the value and the importance of integrated health care deliv-

ery systems.

Relative to quality, how to define it is enormously complex, but I think you have just defined it. Quality is looking at our practice. That is where the real cost saving are, by physicians in integrated health care systems and beyond integrated health care systems, looking at what they do for patients. And it is doing things right the first time it is not doing something if you do not have to do it. One of the best operations out there in American medicine that has the least cost, the highest patient satisfaction, zero complications, is the one that you never do. You cannot measure that—the Government cannot measure that. Patients can measure that when they are on the receiving end.

I think this whole concept of analyzing the practice in a free market and trying to compete against standards of quality, rather than competing against another provider, is what it is all about. The costs are in the utilization, not in the price, and if we can utilize less resources by analyzing the practice in integrated systems, in a market-based reform effort, I think that is where the real op-

portunities are.

So we could not agree more with what you have just said. It is eliminating unnecessary care, but it is also encouraging necessary

care by analyzing the practice.

Senator DURENBERGER. One of the comments you made in your statement was that State-by-State budgeting or any other kind of a budget mechanism would result in I think you said keeping the service at home. Could you give us an example of what you meant?

Dr. WALLER. Sure. If there is a patient in Ohio who has a tertiary care problem and wants to come to Minnesota to a tertiary care center, if the State Government is given a global budget and the responsibility to manage that budget, they might say to that patient: You know, you might be better off staying in Ohio at a ter-

tiary care center and not going to Minnesota—or vice versa.

If there is one thing I could say, Senator, relative to what I hear as a provider from patients every day, it is the whole issue of freedom of choice as we define it; and as patients define it, it is: Am I going to get to come back to where I went last year if I become ill, or am I not? I hear that almost every day now, in the past several months. But I think that is an example of creating a barrier by having a State Government with a global budget wanting to take responsibility for that budget and therefore keep those resources at home and therefore limit the movement of patients across the State line, and therefore create a lot more trouble, I am afraid, than we might realize if we listen to the patient and what he is telling us right now.

Senator DURENBERGER. Steve Wetzell, one of the arguments that I recall Governor Leavitt making in favor of the ERISA preemption was that he cannot do small group insurance reform without the waiver. I do not happen to think that is true, but maybe you could explain two things. One, is that a reason not to do small group insurance reform in Utah, or an other State; and second, would the kind of employer organizations that you represent have some problem with having to live with the guaranteed issue, guaranteed renewal, having the application of that guaranteed issue, guaranteed

renewal the elimination of pre-existing conditions under circumstances, the rating band rules, and a lot of that sort of thing? Do you see that for employers are presenting any kind of a problem

to you?

Mr. WETZELL. Well, first, Senator, the underwriting reform issue is fundamental to any health care reform that we engage in. Our view is the same as Dr. Waller's, that the key to reform is the more appropriate utilization of resources; it is a system issue, not an insurance issue. But below that is the issue of underwriting reform.

I do not think there is any reason why a State cannot undertake small group reform. The frustration we see is large, multi-State employers that fall outside jurisdiction as they decide they want to

regulate everything and solve everything at once.

What we would encourage the States to do in the short term is take what steps they can take, but recognize our concern about getting caught up in 50 different sets of rules. And that is where the Federal Government needs to step in and create the appropriate degree of accountability for multi-State self-insureds like the companies I represent If we do not come to the table and say we are willing to accept that accountability, then we have no role to play, quite frankly. And if we want to stay in the game and provide health care benefits to our employees and be accountable for containing the cost and monitoring the quality of those plans, then we should have the same accountability as commercial insurers and small business reform, and that needs to come from the Federal level

Senator Durenberger. And one of the issues that does not get debated around here very much is the notion of accountable health plans. We have concentrated our debate alliances, as they are now called, and so forth, but the notion of an accountable health plan would incorporate with it the sort of pricing rules and underwriting rules that you talked about. Do I understand you correctly to say that as far as you are concerned, all employers, all plans and so forth, ought to live by the same rules; that we ought to have national rules that relate to the underwriting rules, to the portability, guaranteed issue, and so forth, across this country, and you would advocate that as an employer, and suggest that getting those kinds of rules in place for whatever this new insurance is called accountable health plans is one of the more critical elements in changing the health care system?

Mr. WETZELL. Absolutely. We do not go as far as advocating an employer mandate, and I do not want to be misunderstood in our

position on that.

Senator DURENBERGER. You are talking about employer mandate

for you to pay a portion of the premium.

Mr. WETZELL. Right. What we advocate is for those employers that choose to offer health plans because it is the right thing to do or it is the competitive thing to do in their industry as part of the total compensation package, that is where you need to apply the same accountability in terms of underwriting, pre-existing conditions, benefit sets—although we have some concern there, because you create an entitlement, and that makes us nervous—but if we are not held to the same set of rules, then it is not fair to small business and those who buy commercially-insured products, be-

cause it gives us a certain advantage in the marketplace. That needs to be addressed for the employers that choose to offer self-funded plans, and we advocate that change.

Senator DURENBERGER. OK. I thank you all very much, and on behalf of the committee, we express our appreciation to all of you. Statements of Senators Wellstone. Dodd. Jeffords and Thurmond

will be included in the record.

[Statements of Senators Wellstone, Dodd, Jeffords and Thurmond follow:]

# PREPARED STATEMENT OF SENATOR WELLSTONE

I welcome the distinguished panel of elected officials, Administration officials and health policy analysts joining us today, and I am particularly pleased that three outstanding Minnesotans will be

testifying.

It is surely a mark of Minnesota's intense interest in health care reform that people with so wide a range of views have come to speak on our third panel: Dr. Robert Waller of the Mayo Foundation, Steve Wetzell of the Business Health Care Action Group, and Dr. Glenn Pearson, of the Health Care Campaign of Minnesota.

I am aware that many claims have been made for the Minnesota miracle in health care, as an example of the triumph of the market place in producing low-cost and high quality health care. And indeed many Minnesotans have worked hard to try to address the

crisis of cost and access.

But I would have to say that I do not find much evidence to substantiate the claims. am looking forward to Dr. Pearson's testimony, which I believe will corroborate the view that in fact Minnesota's health care costs are at or slightly above the national average, and are certainly higher than those of neighboring midwest states. I am attaching for the record an exhibit from a recent report by the federal Health Care Financing Administration, published in the Fall, 1993, issue of "Health Affairs," documenting those.

In fact, evidence indicates that HMO prices only begin to moderate in the face of impending limits on health care spending im-

posed by the state.

Further, to the extent that costs have been controlled and quality maintained for some, such as the large employers Mr. Wetzell represents, they have done well at the expense of other Minnesotans.

Precisely because our system is not regulated, health care provid-

ers are able to shift their charges to other payers.

Caregivers like Dr. Pearson can be instructed to spend more time and provide better services to employees of Business Health Action Group members, while other patients are short shrifted.

Because we have been unable in Congress to allow states to bypass ERISA, as both Senator Durenberger and I have proposed, Minnesota has been hamstrung in financing its admirable attempt

to expand coverage for and access to care at the state level.

I appreciate the comments of Governor Waihee and Governor Leavitt on behalf of the National Governors Association, and Representative Buell from the Massachusetts legislature. It is important that the Governors Association acknowledges states' need to have the flexibility to implement single-payer systems at the state level. I could not agree with them more on the need for universal

coverage, and effective cost control. Their efforts certainly point the way to both the possibilities and the pitfalls of state-based reform.

I thank Ken Thorpe for bringing us the latest information from the Department of Health and Human Services, and Rick Curtis for his thoughtful views on the balance of authority we should consider between state and federal roles.

There can be no question that the time is directly before us for

federally-driven health care reform.

The American Health Security Act which I have introduced, S. 491, provides a usable model for a federal government that sets standards and guidelines, while leaving room for states to involve all residents in making important decisions about their health care, and to respond to the local conditions they know best. I will work to see that the national health care reform legislation that we enact this year follows that basic structure.

Exhibit 2
Average Annual Growth In Expenditures For Hospital Care, Physician Services, And Prescription Drug Purchases In Retail Outlets, By Region And State, 1980–1991

Region and state	Total*	Hospital care	Physician services	Prescription drugs
United States	10.5%	9.9%	11.6%	10.6%
New England	10.7	9.4	13.7	11.8
Connecticut	11.1	10.3	12.9	10.5
Maine	10.6	9.6	· 13.1	11.0
Massachusetts .	10.3	8.7	14.3	12.5
New Hampshire	13.4	12.4	15.7	12.8
Rhode Island	9.7	8.8	11.4	11.8
Vermont	11.2	10.2	13.4	12.4
Mideast	10.4	9.6	12.0	11.1
Delaware	12.0	10.8	14.2	12.4
District of Columbia	9.5	9.4	9.8	10.3
Maryland	10.6	8.9	13.3	12.6
New Jersey	11.3	11.2	11.6	11.4
New York	10.1	9.3	12.0	11.0
Pennsylvania	10.3	9.7	11.8	10.7
Great Lakes	9.0	8.5	9.8	10.1
Illinois	8.2	7.5	9.4	10.7
Indiana	10.3	9.9	11.1	9.6
Michigan	8.6	8.2	8.7	10.5
Ohio	9.4	9.2	9.9	9.3
Wisconsin	9.8	8.9	11.3	10.8
Plains	9.7	9.0	11.2	9.7
lowa	8.9	8.7	9.3	9.0
Kansas	9.0	8.1	10.6	9.8
Minnesota	10.5	9.3	12.6	10.0
Missouri	9.7	9.2	11.1	9.6
Nebraska	9.5	9.2	9.9	9.9
North Dakota	9.6	8.8	11.0	10.5
South Dakota	10.6	10.3	11.5	9.3
Southeast	11.6	11.3	12.4	10.7
Alabama	10.7	10.0	12.4	10.1
Arkansas	10.9	11.1	11.5	8.3
Florida	12.5	12.0	13.3	12.5
Georgia	12.5	12.2	13.3	11.5
Kentucky	11.0	11.1	11.3	10.0
Louisiana	10.7	10.6	11.3	9.0
Mississippi	9.8	9.9	9.9	9.5
North Carolina	12.0	12.0	12.6	10.2
South Carolina	12.4	12.7	12.4	10.9
Tennessee	11.0	10.8	11.7	10.3
Virginia	11.6	10.8	13.1	12.0
West Virginia	8.9	8.4	9.6	10.0
Southwest	11.1	11.1	11.3	10.2
Arizona	11.9	11.5	12.3	13.3
New Mexico	12.3	12.1	12.9	12.0
Oklahoma	9.1	9.0	9.5	8.8
Texas	11.2	11.4	11.3	9.8

Exhibit 2
Average Annual Growth In Expenditures For Hospital Care, Physician Services, And Prescription Drug Purchases In Retail Outlets (cont.)

Region and state	Total a	Hospital care	Physician services	Prescription drugs
Rocky Mountain	10.8%	10.6%	11.1%	10.4%
Colorado	10.9	10.4	12.1	10.0
Idaho	10.5	11.0	9.9	9.8
Montana	9.4	10.1	7.8	9.8
Utah	11.7	11.6	11.6	13.0
Wyoming	8.9	9.4	8.2	7.2
Far West	10.5	9.8	11.6	10.3
Alaska	11.4	11.4	11.3	12.0
California	10.3	9.4	11.6	10.5
Hawaii	11.4	12.3	10.0	10.9
Nevada	12.4	10.8	14.7	12.6
Oregon	9.8	9.7	10.2	8.2
Washington	11.7	11.4	12.6	9.4

Source: Health Care Financing Administration, Office of the Actuary, estimates prepared by the Office of National Health Statistics.

per capita spending over time, one can see differences in per capita regional spending levels and growth. In Exhibits 4–6 per capita spending levels are indexed to U.S. per capita spending in each year, thereby measuring each region's percentage difference from the U.S. average. Regional variation in growth is measured by the slope of the line that reflects the change in position relative to the U.S. average level over time. Policymakers are

Exhibit 3
Regional Spending Per Capita For Hospital Care, Physician Services, And
Prescription Drugs, As Percentage Of U.S. Per Capita Spending And As Percentage
Of Personal Income, Calendar Years 1980 And 1991

		Spending per capita (dollars)		Regional spending per capita as percent of U.S. spending per capita		Spending as percent of personal income	
Region	1980	1991	1980	1991	1980	1991	
United States	\$697	\$1,877	100%	100%	7.0%	9.8%	
New England	738	2,112	106	113	7.0	9.3	
Mideast	739	2,105	106	112	6.9	9.5	
Great Lakes	718	1,826	103	97	7.1	9.8	
Plains	697	1,866	100	99	7.4	10.4	
Southeast	623	1,825	89	97	7.3	10.7	
Southwest	644	1,705	92	91	6.7	10.2	
Rocky Mountain	575	1,567	82	83	6.0	9.2	
Far West	780	1,856	112	99	6.8	9.1	

Source: Health Care Financing Administration, Office of the Actuary.

<sup>&</sup>lt;sup>a</sup> Growth in total equals growth in the sum of expenditures for hospital care, physician services, and retail purchases of prescription drugs.

# PREPARED STATEMENT OF SENATOR DODD

I would like to thank the chair for convening this hearing on the important topic of State involvement in health care reform. This subject is so important because it is the States that have been on the front lines in the battle to reform health care in this country. And it is likely that the States will have significant responsibility for carrying out whatever reforms we agree on here in Washington.

The fact is that many States are already well ahead of the Federal Government in the area of health care reform. For a number of years now, State governments have been coming up with initiatives to address the health care problems they face. A report published last summer by the Kaiser Family Foundation found that nearly every State had recently adopted reforms intended to ex-

pand access to health care.

My own State of Connecticut is a case in point. In recent years, it has experimented with a number of reforms. The State has adopted some small group insurance reforms, has expanded children's health insurance programs, and has permitted employers to form health insurance purchasing pools. The Connecticut General Assembly is expected to debate more comprehensive reform in its current session.

Other States have also adopted innovative health care reforms, many of which are now part of the President's initiative. Hawaii relies on an employer mandate to expand health care access to its residents. Tennessee, Florida, Minnesota, Washington, and others recently have enacted far reaching reforms, some of which include

health purchasing alliances.

The President's health care plan builds on this state-level innovation in the cause of federal-level reform. It allows States to tailor their health care efforts to meet their own citizens' unique needs. This is a common-sense approach to reform because different States have different demographic characteristics, different health care delivery systems and different distributions of hospitals.

Some might be tempted to suggest that the innovation going on at the State level makes comprehensive Federal health care reform unnecessary. Such a view, however, would not stand up in the face of the facts. In fact, the Connecticut General Assembly's health care access commission reported last July that "many of the roadblocks to a swift health care solution in Connecticut exist because of anomalies in Federal law that cry out for change." I hope today we will examine some of these obstacles to change at the state-level and will ask how much of the burden of reform we can realistically place on the States.

In any event, the States need our help to continue the reform process, and they are demanding that we act. Just this week, the Nation's governors unanimously called on congress to pass national health care reform this year. This level of bipartisan support for reform is not surprising given what health care costs have done to

State budgets in recent years.

A recent survey by the National Governor's Association found that total State expenditures on Medicaid have now surpassed State spending on education. The health care drain on States' budgets must be plugged, and it is high time that we adopt real reform that will do the job. Using the blue print found in the President's plan, I am confident we can do so while at the same time encouraging further state-level innovation in health care reform.

# PREPARED STATEMENT OF SENATOR JEFFORDS

Mr. Chairman, thank you for holding this hearing on one of the most critical issues in health care reform. This year we have a historic opportunity to achieve health reform at a national level. But enactment of federal legislation does not mean the states will become less important in health care reform, on the contrary, the states role will be key to successful reform.

The worst thing that Congress could do is create uncertainty that undermines state action toward achieving universal coverage. Congress should reward state innovation in health reform, and reject proposals that would reverse or punish states for their innovation

in extending coverage to the uninsured.

As you know, Vermont has been working on health reform for many years and we are on the verge of passing legislation this year. Our business community, providers and consumers are all actively engaged in putting together a system that will work well for the state.

What works for our state may not be the same system that works in New York or California. We don't have a surplus of doctors or hospitals competing with each other for the latest gadgets and glitz. I think we still have but one MRI in the entire state. Thus, I think we have to preserve some measure of state flexibility in any system we adopt.

I also think that we cannot discount the substantial strides that have made by some states already in controlling health care costs.

Vermont's health care costs are just about the lowest in the country, in many respects lower than Canada's.

We need to find a way to reward these states for their efforts, or at the very least not make the false assumption that all states have an equal amount of waste to squeeze out of their systems.

And finally, I think the delineation of responsibilities between the federal and state governments must be clear and fair. I think the more responsibility we can provide to the states, the better off we will be. But if we give states responsibility, we must also give them the means to carry out those responsibilities.

I look forward to hearing the views of our witnesses on these and

other matters.

# PREPARED STATEMENT OF SENATOR THURMOND

Mr. Chairman, it is a pleasure to be here this morning to receive testimony concerning the role of the States under S. 1757, the Health Security Act. I would like to join my colleagues in extending

a warm welcome to our witnesses here today.

Under this legislation, each state will be required to submit a health care reform plan to the National Health Board detailing how the State will comply with the federal rules and regulations established by the Board. The states will have to demonstrate to the National Health Board how they will certify the health plans, administer subsidies for low-income individuals and small employers, collect data on health alliance and health plan performance, and meet federal quality, management and fiscal solvency requirements.

The states will also be under a federal obligation to establish at least one regional alliance for the enrollment of employers and employees in approved health care plans. Further, they must also ensure that all eligible individuals are enrolled in a regional alliance.

The regional alliances must not establish boundaries or rules for an alliance that could lead to discrimination based on race, gender, income, or health risk. Although I agree with the premise that we cannot discriminate on this basis, I am concerned that this requirement may lead to possible "gerrymandering" of the boundaries for the regional health alliances.

I am also concerned that S. 1757 dictates that "the entire portion of a metropolitan statistical area located in a state shall be included in the same alliance area." This requirement may be too broad to cover every metropolitan area in America. I believe this

deserves further consideration.

The States are going to be forced to assume an enormous amount of responsibility regarding health care reform. I am hopeful that our witnesses today will be able to help us properly address the role of the States under the Health Security Act.

Again, I would like to welcome our witnesses here today, and I

look forward to their testimony.

Senator DURENBERGER. Thank you.

[Appendix follows.]

### APPENDIX

### PREPARED STATEMENT OF DR. ROBERT R. WALLER

Mr. Chairman and members of the committee, I am Doctor Robert Waller, President and CEO of the Mayo Foundation. We are pleased to have the opportunity to

testify today on the role of the states in health reform.

The Mayo Foundation is an integrated health care system, with clinics, hospitals, and other health care entities located in five states. These include: Mayo Clinic Rochester, Saint Marys Hospital, and Rochester Methodist Hospital, in Rochester, Minnesota; Mayo Clinic Jacksonville and St. Luke's Hospital, in Jacksonville, Florida; and Mayo Clinic Scottsdale, in Scottsdale, Arizona. We also have merged with Mayo regional practices, including family practice clinics in Decorah, Iowa and Wabasha, Minnesota, and the Midelfort Clinic and Luther Hospital in Eau Claire, Wisconsin. We serve patients from all fifty states, with approximately half of our patients at Mayo Clinic Rochester coming from outside Minnesota. We are engaged in research and education, with over one thousand residents in training at multiple locations.

#### PATIENT NEEDS AND THE HEALTH CARE SYSTEM

A significant portion of the health care delivery system is local, in particular, primary care. However, many patients need care that is often available only outside their local area. Many patients also choose to bypass local providers to seek care at national referral centers. Mayo, and many other referral centers, are both local providers and national referral centers. We are concerned that some of the attempts to reform the health care delivery system ignore the patients' needs to obtain care from the referral centers, and may create barriers for patients seeking care outside of their home state or local area. Our desire is to serve any patient who needs our services, but we cannot help a patient who cannot come to us.

In addressing the role that states might play in health system reform, we are wary of models with the potential of creating patient barriers at state borders. For example, state health budgets, with state enforcement powers, may well create protectionist policies on the part of states to keep the allotted budget "at home". The potential for this reaction on the part of states is particularly strong in instances where state university medical centers may be competing with out-of-state medical

centers to provide tertiary level care.

The issue of interstate patient travel is not unique to Mayo. The attached chart (attachment A), which is based on Medicare data, shows that border crossing for both physician and hospital care, is widespread, and varies considerably by state. For example, 27.6 percent of the physician services furnished in Minnesota was furnished to out-of-state residents, while 11.8 percent of the physician services furnished to Minnesota residents was furnished by providers in other states. In Wyoming, only 6 percent of the physician services was furnished to out-of-state residents, while 36.9 percent of the services furnished to Wyoming residents was furnished by providers in other states.

Our concerns also apply to state created alliances. If these alliances are given regulatory authority, as opposed to a limited role as purchasing clearinghouses, then

the same potential for protectionist policies will exist.

#### A MARKET BASED SYSTEM

We believe that reform of the health system should be market based. Markets do not always follow state or alliance borders. In the case of health care, markets are defined by patients' preferences and choice of provider. Therefore, we believe that states and alliances should not have powers to create rules that will obstruct a patient's right to choose his or her physician or hospital. For example, we strongly support the position that alliances must offer all certified accountable health plans. If states or alliances are permitted to exclude some certified plans, potential prime targets for exclusion will be out-of-state plans, and plans that include out-of-state medical centers who compete with in-state centers. For the same reasons, the role of states in certifying health plans should also be limited, with uniform criteria being set at the national level. If a plan meets the criteria, a market based approach requires that the plan be allowed to freely compete.

We are encouraged by the innovations now underway in the health care market. We are participating in unique arrangements with companies such as John Deere and the Business Healthcare Action Group of Minneapolis and St. Paul that show much promise for both cost containment and quality improvement. We are worried that government health reforms may have the unintended consequence of stifling

this innovation. The possibility of this unintended consequence is multiplied if each state or alliance has the power to dictate another set of rules with which providers and purchasers must deal.

#### STATE AND ALLIANCE FEE SCHEDULES

As supporters of market based reform, we do not support mandated fee schedules set by either the state or the alliances. Competition will apply to fees, and the market should be allowed to freely determine prices. If every state, or every alliance, is given the power to set fees, we would be faced with the prospect of dealing with fifty, or perhaps as many as several hundred, HCFA like entities. This would truly be a nightmare. In establishing these fee schedules, each of these entities could conceivably use different methodologies, and set different standards for coding, record keeping, documentation, utilization review, and a host of other related functions. This would be in addition to variations which we may negotiate with different accountable health plans in which we participate. We would have little or no ability to negotiate with states and alliances to attempt to work out compatible systems if these entities have the power to unilaterally set fees.

Another area where state or alliance variation would create a major problem is the required use of practice guidelines. If different guidelines were developed by different states and alliances, the multistate provider would be placed in an impossible

situation.

#### NATIONAL UNIFORMITY

We believe that national uniformity is necessary in some areas in order to help the market function more efficiently, to guarantee patient access, and to guarantee patient choice. These areas include subsidies for low income individuals to purchase uniform basic insurance, a tax cap on the deductibility of health insurance benefits, insurance reforms (including portability, elimination of preexisting condition exclusions, and guaranteed issue), voluntary purchasing alliances for individuals and small businesses which serve an information clearinghouse function, standardization of billing formats and claims processing, and targeted data collection to enhance consumer decision making. The corollary to this national uniformity is that states and alliances should not have the authority to vary from these standards. Beyond these areas, the market system will serve as the guiding principle.

#### **EDUCATION AND RESEARCH**

Education and research are integral parts of the Mayo system. In both of these areas, we participate in a national market. We recruit students and resident trainees from all parts of the country, and train these individuals to serve national needs. Recent data show that 80 percent of the residents and fellows who have trained at Mayo now practice outside of Minnesota. In the research area, we compete for grants in a national market, and self fund research to serve national needs. We believe that these areas rightfully should continue to be dealt with as national

policies.

If the government is to have a role in limiting the number of physicians and other practitioners to be trained, or the distribution of specialists to be trained, we believe this should be done in the context of national needs. If there are to be limits, the criteria to be used to make any changes in numbers or distribution of residency positions should be based on the quality of the education programs. For example, attempts to mandate primary care training ratios on a regional, state, or medical center basis would ignore the national market in which physicians participate. The Mayo Graduate School of Medicine (our residency training program) is one of the largest (and we believe best) programs in the country. However, it is based in Rochester, Minnesota, a city of less than 75,000 population. If residency positions were to be distributed by state or region based on population, we would have to shut down most all of our programs.

As Mayo has developed its integrated system beyond Rochester, we have also attempted to incorporate our education and research programs into the regional practices. Many of our residents will spend part of their training time in more than one state. This will become more commonplace as primary care training programs expand into clinics in smaller communities. This is another example of how state-by-state distribution formulas would run counter to positive movements now underway

in the education programs.

#### CONCLUSION

Mayo has attempted to participate in a positive way in health care reform. We believe that the market oriented approach offers the best hope for meaningful reform, with some uniform policies at the national level to enhance the market efficiency and provide expanded access to health insurance and health care. We do not believe that states, or state created alliances, should have the power to create their own systems to the extent that those systems would limit interstate patient movement, or create administrative variations that would significantly impede the working of the health care market and our ability to serve our patients.

Table 8. Border crossing by state

Percent

State	Residents'	care purchased o	out of state	Service purchased by nonresidents			
	Hospital charges (1980)	Hospital admissions (1989)	Physicians' services (1989)	Hospital charges (1980)	Hospital admissions (1989)	Physicians' services (1989)	
Alabama	6.4	5.3	8.4	4.6	4.5	5.8	
Alaska	14.7	16.7	25.7	7.8	9.2	12.1	
Arizona	8.5	6.9	8.5	10.6	11.1	11.5	
Arkansas	13.0	8.6	11.8	7.8	7.7	7.7	
California	1.6	2.2	n.a.	2.8	2.4	TOR	
Colorado	4.4	4.8	8.9	8.7	7.0	9.1	
Connecticut	6.2	5.8	6.5	4.8	5.3	7.1	
Delaware	13.3	13.5	17.1	8.9	8.8	41.7	
Dist. of Columbia	9.5	10.6	6.0	31.8	37.6	15.7	
Florida	7.2	8.0	6.6	9.2	8.7	8.1	
Georgia	6.3	4.3	7.3	7.4	6.2	7.9	
Hawaii	2.8	2.9	4.5	5.0	5.2	5.0	
Idaho Illinois	16.9	16.8	23.9	6.7	7.1	7.4	
Indiana	6.0	8.4	10.4	3.4	2.9	4.1	
lowa	7.4	5.5	9.8	7.2	73	8.5	
Kansas	12.1	9.8	17.1	6.8	6.7	7.5	
Kentucky	9.8	10.6	7.1	5.5	5.3	4.6	
Louisiana	4.1	2.7	3.3	5.0	6.1	8.8 4.8	
Maine	8.4	5.5	9.4	4.4	4.6	4.8	
Maryland	11.5	9.3	13.1	7.9	7.6	10.5	
Massachusetts	2.6	3.3	4.4	5.8	5.8	6.9	
Michigan	4.6	5.6	5.6	2.5	2.4	2.7	
Minnesota	6.6	8.0	11.8	10.6	12.8	27.6	
Mississippi	12.6	8.1	14.7	5.8	4.4	6.1	
Missouri	5.2	5.5	9.7	9.3	9.8	14.8	
Montana	10.4	5.7	13.4	5.8	6.0	6.8	
Nebraska	8.3	7.9	12.1	9.9	8.9	12.1	
Nevada	9.5	10.7	12.1	13.5	16.4	18.6	
New Hampshire	18.7	15.6	23.1	14.2	13.3	16.2	
New Jersey	10.5	8.2	12.0	4.3	4.2	8.1	
New Mexico	15.0	10.0	13.8	7.6	6.8	5.4	
New York	4.0	4.7	n.a.	4.1	3.9	n.a.	
North Carolina	5.7	4.1	5.6	5.4	4.9	15.2	
North Dakota	10.4	8.5	7.9	18.0	16.8	20.2	
Ohio	4.6	5.4	6.3	4.7	4.2	5.2	
Oklahoma	7.8	8.2	10.2	3.7	3.4	4.7	
Oregon	5.3	5.7	8.4	6.7	7.9	6.8	
Pennsylvania Rhode Island	3.6	3.7	5.4	4.6	4.8	6.1	
South Carolina	6.9	6.9	8.4	7.1	7.1	6.7	
South Carolina South Dakota	10.6	8.2	13.7	4.2	3.7	3.9	
Tennessee	3.8	10.8	13.6	10.6	11.3	17.1	
Texas	2.4	2.4	2.7	13.8	11.1	13.8	
Utah	4.9	4.3	6.6	5.3	9.2	4.8 8.7	
Vermont	21.9	16.3	24.3	13.0	14.4	16.6	
Virginia	8.3	7.7	12.3	7.0	6.4	5.5	
Washington	5.6	6.1	5.6	5.8	5.2	5.5	
West Virginia	14.0	12.5	15.3	11.3	11.5	13.3	
Wisconsin	6.1	5.6	8.1	5.1	5.4	6.1	
Wyoming	25.5	18.3	36.9	7.1	6.8	6.0	

n.a. Data not reported by state in original source.

Source. Levit 1985; Miller and Welch 1992; Holahan and Zuckerman 1991.

# PREPARED STATEMENT OF GOVERNOR MICHAEL LEAVITY

### A BLUEPRINT FOR MARKET-ORIENTED HEALTH CARE

At the request of Governor Leavitt, the 1993 Utah Legislature established the Health Care Policy Option Commission to propose options for reforming the state's health care system. The commission completed its work and issued a final report in December 1993. The Governor has reviewed the health care reform options recommended by the commission and now introduces Utah Healthprint — a blueprint for market-oriented health care. Healthprint establishes a rational process for providing affordable health care coverage for all Utahns.

### The Target

Utah Healthprint will increase access to affordable insurance coverage for all Utahns. Individuals will not be turned down by health insurers because of a preexisting condition. Employees will not be locked into a job for fear of losing their health insurance. Healthprint will change the rules of the marketplace in order to provide the security of health care coverage for all Utahns.

The spiraling rise in health care costs will be contained through enhanced competition. Through increased consumer involvement and a change in provider incentives, the health care market would have increased price competition—a proven method of cost control.

The high level of quality health care enjoyed by Utahns will be maintained. In fact, the quality of care will increase as providers make continuous improvements required by a competitive environment.

The enactment of Healthprint will begin true health care reform in Utah. Many health reform plans look good on paper but never get tried. Healthprint is a politically feasible solution because it provides a reasonable process for reforming the health care system.

### **Environmental Assumptions**

In developing Healthprint, six major environmental assumptions were recognized and considered.

- Change will occur whether or not the state does anything. Through action, the state can influence the direction of the changes.
- The federal government plays a major role in health care reform whether we like it or not. A national plan could completely undo our state effort. Even without a national plan, exemptions and waivers are required from the federal government to implement state reforms.
- Because the current health care market is in flux, the reform process must be flexible and adaptive to change.
- The state is limited in its ability to address all the complex issues of health care in a 45-day legislative session. At the national level, tremendous resources have been devoted to the health care debate; it could span several years.
- Although they sound good, many of the recommended solutions are untried. The health reform process must allow testing of proposals and flexibility to change direction if they do not work.

 Health system reform will take sustained effort and leadership. The Governor is committed to lead the health care reform effort and keep the state moving toward its target of increased access to affordable care.

## **Basic Strategy**

The basic strategy of Utah Healthprint is to define a flexible master plan. This master plan is a blueprint of the many decisions that need to be made. Annual decision points will occur each 45-day legislative session. The Utah Legislature would debate and enact reforms each year to bring the state closer to target. The state should take a major first step forward in 1994 to commit itself to the target and reform process. A mechanism to make the process succeed is the creation of the Utah Health Policy Commission. As chair of the Commission, the Governor would work with legislators and other appointed members to study health system issues in the flexible master plan and make recommendations for each legislative session. The Commission would also recommend changes to the flexible master plan as shifts occur in the health care environment. Figure 1 illustrates this basic strategy.

Figure 1
Basic Strategy of Utah Healthprint



#### **Basic Decisions**

In formulating the flexible master plan, the following five basic questions had to be answered:

- 1. Should the employer or individual be responsible for coverage?
- 2. Should we fix the market or create a government-run system?
- 3. Should we implement comprehensive reform all at once (big bang) or follow a master plan (blueprint) that directs us to a target?
- 4. What level of choice should consumers have?
- 5. How do we pay for increased access?

These questions were answered as follows:

- 1. Individuals should be responsible for their own health coverage.
- We should fix the problems in the current market by enhancing competition rather than setting up a government-run system.
- We should avoid the "big bang" theory of health care reform, which makes hundreds of complex decisions all at once. A flexible plan is a more reasonable approach than being locked into untried solutions.
- 4. The level of choice should be decided by the consumer purchasing the health care. We know that unlimited choice increases costs and restrictions lower costs. The consumer is most able to make this cost-conscious decision.
- 5. The four basic methods to finance reform, in order of preference, are: 1) savings, or doing more with what we have; 2) higher insurance premiums; 3) general taxes; and, 4) cost shifting. All four methods will likely continue to finance health care for some time. However, no new taxes are required to implement Healthprint.

## Flexible Master Plan

The flexible master plan addresses the goals of access, cost containment, and quality. This blueprint contains today's ideas for reforming the health care system. The blueprint is flexible and expected to change as new information is available and as transformations take place in the health care market.

#### Access

The three main strategies to increase access are: 1) insurance reform, 2) Medicaid expansion, and 3) creation of a co-op. The federal government would need to be involved to allow the state to achieve universal coverage. Currently, 89 percent of Utahns have either public or private health insurance. Figure 2 illustrates the plan for expanding access to all Utahns.

Figure 2
Access Plans for the Uninsured

Federal income transfer

Co-op

Medicaid expansion

Insurance reform

#### Insurance Reform

The following insurance reforms would take place in 1994 as a part of a major "first step":

- Insurers would provide dependent coverage up to age 26. Many college students who qualify
  as dependents do not have health insurance. This reform would require an insurance company
  to include them in the health plan.
- Premiums would be community rated for small groups, allowing insurers to vary premiums only on the basis of age, gender, and geography. To promote prevention and healthy lifestyles, insurers may also give individuals discounts for healthy behavior.
- Small groups would receive guaranteed renewability of insurance. Insurers could not cancel
  or refuse to renew coverage of a health insurance policy except for failure of the insured to
  meet contractual obligations, such as non-payment of premiums.

Additional insurance reforms would take place over the next few years. For example, insurers could not exclude coverage of any preexisting medical condition for anyone who changes insurance plans. This would allow portability of insurance for individuals changing jobs. Employees would no longer be locked into a job for fear of losing their health coverage because of a preexisting health condition. A slight increase in insurance premiums is expected, initially, as a result of these reforms. Eventually, the increase will be offset by the decline in premiums due to Healthprint's cost containment strategies.

#### Medicaid Expansion

The second method to increase access is through an expansion of the Medicaid program. Medicaid is a federally-aided program that is operated and administered by states. The program provides medical benefits for certain indigent or low-income persons in need of medical care. For every dollar the state pays, the federal government contributes three dollars. Medicaid would be expanded in the following four phases and would be financed by the savings generated from changing the way the system operates.

- Phase I would provide coverage for all children age 11-17 who are living below the federal poverty level. The state health department estimates that this would provide coverage for approximately 32,000 additional children.
- Phase II would provide medical coverage to all aged, blind, and disabled individuals below the federal poverty level.
- Phase III would expand Medicaid to cover all others below the poverty level. A waiver from
  the federal government is necessary to allow expansion in phase III.
- Phase IV of the Medicaid expansion would be a federal income transfer that subsidizes the insurance premium for those between 100 and 150 percent of the federal poverty level. This is an appropriate role for the federal government because the state does not have a sufficient tax base to finance a subsidy by itself. Universal access cannot be achieved without this federal income transfer.

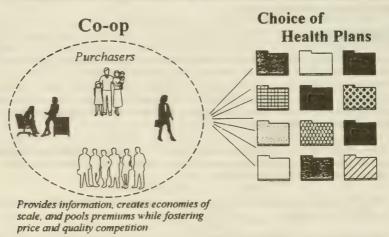
Phases I through III would be expanded through savings in the Medicaid program. Under the current Medicaid system, recipients can go to any provider, whenever and as often as they like. This blank-check system provides incentives for over utilization of health care services. The new system for Medicaid reimbursement is to provide health care in capitated, managed care settings. "Capitation" is a method of payment for health services in which an individual or provider is paid a fixed dollar amount for each person served, regardless of the actual number or nature of services

provided to each person in a set period of time. Capitation is the characteristic payment method used in health maintenance organizations. This places providers at financial risk, rather than the state, and gives providers incentive to keep their members healthy. Limited choice would remain for Medicaid recipients because they could choose which capitated health plan to join. The state has already begun this new method of reimbursement for 20 percent of Medicaid clients and is financing the first phase of the expansion through actual savings. Expansion into the second and third phases would occur as actual savings accrue from the increased use of capitated reimbursement.

#### Co-op

The co-op is the sponsor for the small group and individual market. Individuals and small employers commonly lack access due to the unaffordability of insurance. The co-op would pool small groups and individuals to allow them to experience the same administrative economies of scale that large companies experience when purchasing health benefits. The co-op would also allow increased choice for employees working in small firms. Currently, many who work for small employers have a choice of only one health plan. Through the co-op, a choice of plans would be made available to employees of small employers. Figure 3 depicts how the co-op would function.

Figure 3
Function of Co-op in Providing Health Care to Individuals and Small Groups



#### Cost Containment

Medical costs are escalating at a rate that we cannot afford. Utah Healthprint envisions two major elements of cost containment. The first is enhanced competition through the co-op. The second is a greater use of capitation.

The co-op provides a platform for competition. It promotes price and quality competition among health plans by giving individuals information needed to make intelligent, cost-conscious choices. Increased consumer involvement is absolutely necessary as a cost containment tool. Small employers are too small to achieve administrative economies of scale that large corporations experience when purchasing health benefits. Average administrative expense for groups under five people is estimated as high as 40 percent of premium versus 5 percent for groups over 10,000 people. The co-op would provide these economies of scale to individuals and small group purchasers.

Under the co-op framework, use of capitation as a reimbursement method for health plans would increase. Capitation changes the provider's incentive from offering unlimited services to providing services that will promote the health of patients in the long run. It is also likely that medical savings accounts would be offered through the co-op. Medical savings accounts (MSA) allow individuals to purchase a high-deductible policy and put the premium cost differential into a medical savings account to pay for routine medical care. The funds in an MSA would belong to the insured and, if unspent, accumulate over time as savings to pre-fund future health care needs.

## Quality

As health system reform is undertaken, quality of care must not diminish. In fact, Utah Healthprint anticipates an increase in quality as health plans not only compete on price but are also measured on quality. Health plans would have incentives to continuously improve their processes to provide improved outcomes for their patients. Under a co-op, consumers would be provided information on patient satisfaction for each health plan. They would also be given information on differences in medical outcomes between health plans.

Quality improvement must occur from the bottom up and not from a government-mandated top down approach. Providers of care have an essential role in recognizing needed improvements, designing improvement strategies, and carrying out improvement projects. The most effective improvements will occur when energy is devoted to systematically identifying and improving specific, targeted care processes. Through such a process, a local hospital was able to reduce the infection rate for major abdominal surgery from 1.8 percent (the acceptable national average was 2 to 4 percent) to 0.4 percent, which increased customer satisfaction, reduced the length of hospital stay, and saved the hospital approximately \$750,000 in a single year. This quality improvement paradigm shows that it is possible to increase quality while decreasing costs. The quality approach recommended in Healthprint provides the incentives for such innovations.

## UTAH HEALTHPRINT

	1994	1995	1996
ACCESS	Medicaid expansion (L) children ages 11-17 below 100% of poverty Insurance reform (L) cover dependents to age 26 small group modified community rating guaranteed renewability  Licensible of the control	Medicaid expansion (L) aged, blind, disabled below 100% of poverty Insurance reform (L) preexisting conditions waived	Medicaid expansion (L) - adults below 100% of poverty (Medicaid waiver approved) Insurance reform (L) - system-wide modified community rating portability guaranteed issue - risk adjustment mechanism
	Uninsurable risk pool funding increased (L)  Request federal tax change (L)  self-employed and individuals	Public health plan (L)  State tax change (L)  self-employed	Special populations plan (L) State tax change (L) individuals
	Medicaid waiver application	Medicaid waiver state approved/forwarded (L)	
	Administrative simplification  Designated benefits offering (L)	Electronic submission of claims  Self-referral limitations (L)	Voluntary capitated managed care for companies with >50 employees promoted
COST CONTAINMENT	Medicaid capitation 40% of clients	Medicaid capitation 65% of clients	Medicaid capitation 100% of clients
	Request federal tax change (L) - medical savings account	Tort reform (L)  Anti-trust reform (L)	Co-op created (L)  health plans approved  medical savings account option
		Healthy lifestyles education (L)	

QUALITY	Practice guideline efforts continued	Quality process implementation begins (L)	Quality process implementation continued (L)
	Data systems improved (L)		Medical education reform (L)
	Create Health Policy Commission (L)	Commission evaluation and recommendations review prior reforms	Commission evaluation and recommendations review prior reforms
		· recommend new reforms	· recommend new reforms
STUDY AND EVALUATION	Study items federal reforms tort reform self-referral limitations anti-trust reform rural health care public health quality process healthy lifestyles education medical ethics access/cost/quality monitoring insurance reform state tax equity	Study items federal reforms co-op special populations rural health care quality process medical education reform primary care financing education system insurance reform state tax equity	Study items federal reforms rural health care alcohol/drug reatment long-term care workers comp/auto health insurance alternatives to capitated reimbursement benefit plans review

(L) = Legislative action required.

1997	1998	1999	2000
			Employer/individual mandate? (L) Uninsurable risk pool integrated? (L)
Rural health plan (L)  Alcohol/drug treatment plan (L)	Long-term care plan (L)	Mental health plan (L)	
Alternatives to capitated reimbursement (L)  Co-op (L)  emoliment for individuals and employers with <50 employees	Workers composanto health insurance integrated (L)  Public sector co-op? (L)	Medicare integrated? (L)  Medicaid co-op? (L)	Co-op (L) - enroll employees with 50-100 employees?
Health plan report cards			
Commission evaluation and recommendations - review prior reforms - recommend new reforms	Commission evaluation and recommendations review prior reforms recommend new reforms	Commission evaluation and recommendations review prior reforms recommend new reforms	Commission evaluation and recommendations review prior reforms recommend new reforms
Study items - federal reforms - mental health - workers comp/auto bealth - insurance? - long-term care - benefit plans review - public sector co-op?	Study items federal reforms mental health Medicial co-op? Medicare integrated? benefit plans review	Study items foderal reforms oo-op effect on access/cost/quality include employers with 50- 100 employees? employer/individual mandate? uninsurable risk pool? benefit plans review	Study items - foderal reforms - access/cost/quality - benefit plans review

### **EXPLANATION OF HEALTHPRINT TERMS**

## 1994

#### **ACCESS**

Medicaid expansion will provide medical coverage to all children under 18 years of age below the poverty level. This expansion will increase the number of children covered by approximately 32,000.

#### Insurance reform includes:

**Dependent coverage to age 26** which will require insurers to offer coverage for all unmarried tax dependents up to age 26;

Small group community rating with modifications for age, gender, and geography. Premium discounts may also be given for healthy lifestyles; and

Guaranteed renewability which will require insurers to renew all policies, unless the employer or insured individual fails to comply with contract requirements such as failure to pay premiums.

Uninsurable risk pool funding increased by \$1,500,000. This pool was established in 1990 to provide low cost access to health insurance for those who are denied adequate insurance and are considered uninsurable.

Changes in federal tax law will be requested to allow individuals purchasing insurance the same tax benefit as those who receive health insurance through their employer.

A Medicaid waiver application will be written to provide Medicaid coverage for all adults below the poverty level. The expanded coverage will be financed by savings in the Medicaid program.

#### **COST CONTAINMENT**

Administrative simplification will create efficiencies in the system. The Utah Health Information Network (UHIN) is a leading organization in the standardization of claim administration practices, electronic data interchange, and the establishment of an information repository.

A designated benefits offering will require insurers to quote a price on designated benefits, as well as offer the designated benefit plan to facilitate price comparison.

Medicaid capitation will provide cost savings as clients are moved into prepaid HMO and other managed care arrangements. In 1994, 40 percent of Medicaid recipients will be in a capitated system.

Changes in federal tax law will be requested to allow Medical Savings Accounts comparable tax treatment as other health plans.

#### QUALITY

Practice guidelines effort will continue through the Effective Practice Patterns Subcommittee which is working on the dissemination of practice guidelines.

Data systems will be improved to provide the information necessary to measure the effectiveness of Utah's health care system. As a first step, additional funding is recommended for the Utah Health Data Committee to begin work on establishing a central data repository.

#### STUDY AND EVALUATION

A Health Care Commission will be established to study health system issues and recommend additional reforms. This eleven-member commission will be chaired by the Governor. The commission has the responsibility to direct the efforts outlined in Utah Healthprint.

Study items for the commission for 1994 include:

Federal reforms - to monitor federal action and determine its impact on the state;

Tort reform - to study changes in tort law that would reduce defensive medicine;

Self-referral limitations - to study the need for health care professional limitations on self-referral:

Anti-Trust - to determine the need for and actions required for state-action immunity from anti-trust laws for the collaborative use of expensive medical equipment and for the establishment of approved health plans;

Rural health care - to review the most appropriate delivery system for rural areas that will provide access to essential health care services;

Public health - to develop a public health plan that defines standards for public health and recommend improvements to the system;

Quality process - to define a quality system that continuously improves processes and provides appropriate consumer protection:

Healthy lifestyles education - to increase the awareness of healthy lifestyles for Utah residents; Medical ethics - to determine the method for making ethical medical decisions;

Access/Cost/Quality monitoring - to establish a baseline and process that measures the effects of reform on access, cost, and quality;

Insurance reform - to review the possible elimination of preexisting conditions; and,
State tax equity - to determine how to give self-employed individuals the same treatment for health benefits that employees receive.

## 1995

#### ACCESS

Medicaid Expansion would cover all aged, blind, and disabled below the federal poverty level.

Insurance reform would be presented to the legislature and require:

Preexisting conditions to be waived at the initiation of the program. Insurance coverage will have no exclusions or waiting periods on preexisting conditions for continuously covered individuals.

The public health plan developed by the Commission would be presented to the legislature.

A state tax change would be presented to the legislature and would allow self-employed individuals the same treatment for health benefits that employees receive.

The Medicaid waiver to expand access to adults below the poverty level would be presented to the state legislature for approval and forwarded to the United States Department of Health and Human Services.

#### COST CONTAINMENT

**Electronic submission of claims** would be implemented statewide. The Utah Health Information Network is developing standards to be used for electronic data interchange.

Self-referral limitations would be presented to the legislature.

Medicaid capitation would provide cost savings as clients are moved into prepaid HMO and other managed care arrangements. In 1995, 65 percent of Medicaid recipients will be in a capitated system.

Tort reform would be presented to the legislature in order to reduce the anxiety of legal action which has produced an environment of defensive medicine in the provider community.

State-action exemption from anti-trust laws would be presented to the legislature to encourage collaborative use of expensive medical equipment.

The healthy lifestyles education plan developed by the commission would be presented to the legislature.

#### QUALITY

A system-wide quality process would be presented to the legislature and maintain the high level of quality enjoyed by Utah residents. This effort would be phased in over several years.

#### STUDY AND EVALUATION

**Evaluation and recommendations** for reforms would be ongoing tasks of the Commission. The Commission would evaluate the effectiveness of prior reforms and recommend new reforms from the items studied during the year.

#### Study items:

Federal reforms - to monitor federal action and determine its impact on the state;

Co-op - to determine the structure, membership, costs, benefit plans, guidelines for medical savings accounts and health plan approval criteria for the purchasing cooperative construct; Special populations - to insure access for the homeless, migrant workers, and those who face geographic, cultural, linguistic and physical barriers;

Rural health care - to review the most appropriate delivery system for rural areas that will provide access to essential health care services:

Quality process - to define a quality system that continuously improves processes and provides appropriate consumer protection;

Medical education reform - to increase the number of primary care professionals and determine the financing system for professional medical education;

Insurance reform - to review system-wide modified community rating, portability, and guaranteed issue; and,

State tax equity - to determine how to give individuals the same treatment for health benefits that employees receive.

# 1996

#### **ACCESS**

Medicaid expansion would provide coverage to all adults whose income falls below 100 percent of poverty.

Insurance reform would be presented to the legislature and include:

System-wide modified community rating with modifications for age, gender, and geography. Additionally, discounts to premiums may be given for healthy lifestyles;

Portability which allows an employee who is changing jobs to transfer their insurance and not lose coverage;

Guaranteed issue which requires that all insurers must accept all employer groups or individuals; and,

A risk adjustment mechanism required by the likelihood of adverse selection.

A special populations plan developed by the Commission would be presented to the legislature. This plan would insure that all citizens with special needs and disabilities are provided access to health care services.

A state tax change would be presented to the legislature to allow individuals the same treatment for health benefits that employees receive.

#### COST CONTAINMENT

Voluntary capitated managed care for companies with greater than 50 employees would be promoted to obtain cost control for groups operating outside the co-op.

Medicaid capitation would reach 100 percent of Medicaid clients in 1996.

A co-op option would be presented to the legislature to allow small employers and individuals economies of scale in the health insurance market. The co-op could offer health plans which have met state insurance solvency criteria. One of the health plans could be a medical savings account option, which would allow individuals to purchase a high-deductible policy and put the premium cost differential into a medical savings account.

### QUALITY

A system-wide quality process would continue to be implemented to maintain the high level of quality enjoyed by Utah residents. This effort would be phased in over several years.

A medical education reform plan would be presented to the legislature to produce more primary care providers in Utah including physicians, nurses and other health care professions.

#### STUDY AND EVALUATION

Evaluation and recommendations for reforms will be ongoing tasks of the Commission. The Commission would evaluate the effectiveness of prior reforms and recommend new reforms from the items studied during the year.

Study items for the commission in 1996 include:

Federal reforms - continue to monitor federal action and determine its impact upon the state; Rural health care - conclude the review of the most appropriate delivery system for rural areas that will provide access to essential health care services;

Alcohol/drug treatment - to determine the most appropriate system and reimbursement methods for alcohol and drug abuse treatment;

Long-term care - to review the long term care task force recommendations:

Workers compensation/auto health insurance - to determine the feasibility of merging workers compensation and auto health insurance under a single management structure;

Alternatives to capitated reimbursement - to study alternatives to capitated reimbursement systems, particularly in rural areas; and,

Benefit plans review - to review designated benefit plans which facilitate price comparisons.

# 1997

#### **ACCESS**

The rural health plan based on the commission's study would be presented to the legislature.

The alcohol/drug treatment plan based on the commission's study would be presented to the legislature.

#### COST CONTAINMENT

Co-op enrollment would be presented to the legislature for final approval and would occur for individuals and employers with fewer than 50 employees, who are purchasing insurance.

Alternatives to capitated reimbursement would be presented to the legislature.

#### QUALITY

**Health plan report cards** assessing the quality of care delivered by existing health plans would be published.

#### STUDY AND EVALUATION

**Evaluation and recommendations** for reforms will be ongoing tasks of the Commission. The Commission would evaluate the effectiveness of prior reforms and recommend new reforms from the items studied during the year.

Study items for the commission for 1997 include:

Federal reforms - continue to monitor federal action and determine its impact upon the state; Mental health - to develop a plan to improve the quality and access of mental health care; Workers comp/auto health insurance - to develop a plan to integrate worker's comp and auto health insurance into a single management structure based upon studies from 1996;

Long term care - to develop the plan for long term care based upon studies from 1996;

Benefit plans review - to review designated benefit plans which facilitate price comparisons; and

Public sector co-op - to study the need for a public cooperative as described above for private individuals seeking health insurance.

# 1998

#### **ACCESS**

The long-term care recommendations would be presented to the legislature.

## COST CONTAINMENT

Workers compensation and auto insurance would be presented to the legislature depending on the result of the prior year study.

A public sector co-op would be presented to the legislature depending on the results of the prior year study.

#### STUDY AND EVALUATION

Evaluation and recommendations for reforms will be ongoing tasks of the Commission. The Commission would evaluate the effectiveness of prior reforms and recommend new reforms from the items studied during the year.

Study items of the Commission for 1998 include:

Federal reforms - to monitor federal action and determine its impact on the state; Mental health - continue review and study of mental health reform implementation:

Medicaid co-op - to study the feasibility and appropriateness of including the non-long term care portion of Medicaid into a co-op;

Evaluate Medicare - to study the feasibility and appropriateness of integrating Medicare into Utah health reform efforts; and,

Benefit plan review - to review designated benefit plans which facilitate price comparisons.

# 1999

#### **ACCESS**

Mental health reforms would be presented to the legislature.

#### COST CONTAINMENT

Medicare integration would be presented to the legislature depending on the outcome of the feasibility and appropriateness studies.

Enrolling Medicaid recipients in a co-op would be presented to the legislature depending on the outcome of the feasibility study. Long-term care would likely be excluded.

#### STUDY AND EVALUATION

Evaluation and recommendations for reforms will be ongoing tasks of the Commission. The Commission would evaluate the effectiveness of prior reforms and recommend new reforms from the items studied during the year.

Study items of the Commission for 1999 include:

Federal reforms - to monitor federal action and determine its impact on the state;

Co-op - to determine effect, if any, of the co-op on access, cost and quality of health care. Also to assess the feasibility and appropriateness of including employers with 50-100 employees in the purchasing cooperative;

Employer/Individual mandate - to assess accessibility to health care and determine if there is a need for an employer/individual mandate to provide insurance;

Uninsurable Risk Pool - to assess the future need of the uninsurable risk pool; and,

Benefit plan review - to review designated benefit plans which facilitate price comparisons.

## 2000

#### **ACCESS**

Employer/individual insurance mandates would be presented to the legislature if deemed necessary to achieve access goals.

The uninsurable risk pool integration would be presented to the legislature depending on the results of the prior year study.

#### COST CONTAINMENT

Co-op expansion to include employers with 50-100 employees would be presented to the legislature depending on the results of the prior year study.

#### STUDY AND EVALUATION

**Evaluation and recommendations** for reforms will be ongoing tasks of the Commission. The Commission would evaluate the effectiveness of prior reforms and recommend new reforms from the items studied during the year.

Study items of the Commission for the year 2000 include:

Federal reforms - to monitor federal action and determine its impact on the state;

Access, cost containment, and quality - to evaluate overall progress in achieving access, cost containment and quality; and,

Benefit plans review - to review designated benefit plans which facilitate price comparisons.

# APPENDIX A QUESTIONS AND ANSWERS ON HEALTHPRINT

#### 1. Why do we need health care reform?

Approximately 200,000 people in Utah are currently uninsured and may lack access to needed health care. Additionally, medical costs are rising at a rate we cannot afford.

## 2. Does the plan provide universal access to health care?

Increased access to affordable insurance is the goal of Healthprint. The goal is to be achieved over several years as actual savings are realized.

## 3. What will the proposed health plan do to contain health care costs?

Market forces, increased consumer responsibility, a co-op, administrative savings, capitation, and managed care are major cost containment strategies.

## 4. Are employers mandated to provide insurance to their employees?

No. The individual is responsible for having health insurance. Financial assistance would be provided eventually for those who are below 150 percent of the poverty level.

# 5. Is a tax increase necessary to implement Healthprint?

No new taxes are required.

## 6. Will individuals have a choice of plans or choice of benefits within a plan?

Yes, consumer choice will be preserved and enhanced for individuals and small group purchasers.

## 7. Will individuals have a choice of provider?

Yes, but the plan anticipates increased use of managed care and capitation. When a consumer joins a managed care plan, provider choices may be limited to those participating in the plan.

# 8. What if I get sick during one year? Does that mean the insurer can drop my coverage or hike my premiums, like they often do today?

No. Insurance reforms will be implemented over the next few years to preclude this from happening.

## 9. What is insurance reform?

Refers to the changing of current insurance laws and practices to require such features as guaranteed issue, modified community rating, and portability of insurance from job to job. It may also include prohibitions against preexisting condition exclusions.

#### 10. What is guaranteed issue?

Any person, regardless of age, health condition, etc., will be eligible to purchase a health care plan.

#### 11. What is modified community rating?

A method of calculating health plan premiums allowing modifications in rates for age, gender, and geography. Additionally, discounts to premiums may be given as incentives for healthy lifestyles.

## 12. What is portability?

Employees can change jobs without losing their health insurance. This eliminates "job lock".

#### 13. Will preexisting conditions be covered?

Yes, after all anticipated insurance reform is implemented.

## 14. Will my insurance premiums go up?

It depends. They will go up for some and down for others and for many individuals and employers remain the same. They would increase slightly as insurance reforms are implemented but will decline as small businesses benefit from participating in large purchasing pools.

## 15. What is a co-op?

The co-op is the sponsor for the small group and individual market. The co-op would allow a pooling of risk and reduce the variation in premiums for small groups and individuals. The co-op would increase choice to employees working in small firms with a menu of health plans made available to them. The co-op would give individuals and small groups the same access to benefits plans now enjoyed by employees of large employers.

## 16. What is the role of agents and brokers?

The role of agents and brokers is likely to change for this market segment They could operate as benefit consultants to small employers in the enrollment of employees into the co-op.

# 17. How is the state plan different from the federal plan?

The state plan has many fundamental differences from the Clinton proposal. A few examples of the differences are as follows:

Clinton: Health care reform can be fixed all at once with hundreds of complex, interrelated decisions made correctly.

State: Health care reform is a process that will require a sustained effort to ultimately reach the goal of affordable access.

Clinton: Access would be expanded immediately and financed by estimated savings.

State: Access would be expanded as actual savings are realized.

Clinton: A National Health Board would be created to regulate and enforce the national plan.

State: A Health Policy Commission would study important issues and make recommendations to the legislature.

Clinton: Costs would be contained through a global budget in the form of premium caps. The National Health Board would enforce these budgets, which will likely lead to rationing of

State: Costs would be contained by increasing the competitive forces in the market place.

Clinton: Employers would be mandated to provide coverage to their employees. This would likely lead to job losses in industries that cannot currently afford to buy coverage.

State: Individuals have a responsibility for their own coverage. Subsidies would eventually be enacted to help individuals receive coverage.

## 18. How will a federal health plan influence the state plan?

Until a federal health plan is approved, it is impossible to perceive the impact a federal plan would have on the state plan.

# 19. How will federal and state tax laws be changed to benefit the self-employed and individuals?

The legislature will be asked to approve a change in state tax laws to allow self-insured and individuals to deduct the full amount of health insurance premiums.

# 20. What will be the effect of expansion on the Medicaid budget?

It is anticipated that expansion of Medicaid will be largely funded through savings due to Medicaid capitation, Medicaid client cost sharing, and utilization of funds now available through the Utah Medical Assistance Program.

# 21. Will the expansion of Medicaid reduce the scope of services?

Reductions are not anticipated at this time.

### 22. What does capitation mean?

A method of payment for health services in which an individual or provider is paid a fixed dollar amount for each person served, regardless of the actual number or nature of services provided to each person in a set period of time, usually a year. Capitation is the characteristic payment method used in health maintenance organizations but is unusual for most private physicians' services.

# 23. What is a medical savings account?

Medical savings accounts (MSA) allow employers, self-employed individuals, and others to purchase a high deductible policy and put the premium cost differential into a medical savings account to pay for routine medical care. The funds in an MSA would belong to the insured and, if unspent, accumulate over time as savings to pre-fund future health care needs.

## 24. Will the plan affect the quality of health care?

There is sufficient consumer choice in the plan to safeguard the present quality of care in the health system.

#### PREPARED STATEMENT OF GOVERNOR JOHN WAIHER

Good morning Mr. Chairman and members of the committee. We appreciate the opportunity to appear before you today on behalf of the nation's Governors to discuss national health care reform.

In this statement, we would like to summarize several major issues as follows:

- 1. The Governors' health care reform policy.
- 2. The appropriate state role in health care reform.
- 3. The Governors' reaction to President Clinton's Health Security Act.
- 4. The potential economic impacts of health care reform.

#### The Governors' Health Care Reform Policy

Health care reform has been a major priority for both NGA and individual Governors over the last few years. The nation's Governors have pursued health care reform policy on two tracks. The first calls for the enactment of a comprehensive federal framework with state flexibility and the second calls for immediate enactment of those federal legislative changes that are necessary to allow states to move now to effectively reorganize the delivery system, increase access, and restrain costs.

Last February, the Governors adopted a comprehensive policy on national health reform that calls for universal access to affordable quality health care. The policy supports a national health care system that recognizes the importance of a federal framework for health reform, but at the same time recognizes the essential roles and responsibilities of states. The Governors support a framework inclusive of managed competition that guarantees universal access to coverage. It would include a core national benefits package that is tax deductible, emphasizes primary and preventive care and allows portability of coverage; insurance reforms that address guaranteed renewability, portability, and availability; tort reform; antitrust changes; administrative simplifications; and the development of national health outcomes so that Americans can assess the quality of their health care. The policy also allows for purchasing cooperatives at the state level. While the Governors' policy addresses purchasing cooperatives, it does not specify that they should be mandatory or voluntary and there are differences of opinion among Governors on this issue.

The Governors believe that strong cost control systems are integral to any health care reform system adopted for the nation, but effective cost control can be achieved only in conjunction with universal access. As a group Governors do not endorse enforceable budgets, preferring budget targets instead. We reasoned that setting enforceable budgets for one-seventh of the American economy requires a stable and objective national data system that does not now exist. And, finally, the Governors call for major reform of the Medicaid program so that all current Medicaid recipients would receive their acute care coverage in a managed care setting.

While the Governors pledge to continue working with President Clinton and Congress to enact comprehensive reform, we also believe that a number of reforms should be pursued now. Those reforms include permitting states to implement Medicaid managed care programs through state plan amendments as opposed to waivers, and the establishment a waiver process for ERISA so that states have the opportunity to implement broad-based financing mechanisms for state reform and to include self-insured plans in state-based reform programs. Managed care for the acute care portion of Medicaid will help recipients get appropriate prevention-oriented care. This will increase the quality of care in the Medicaid program, contribute to cost control, and finally provide a medical home for beneficiaries who historically have had trouble finding reliable care.

#### The Appropriate State Role in Health Care Reform

Let us be clear, Mr. Chairman, the Governors do not want to have fifty different state programs. Governors want portability of health care benefits from state to state that are tax deductible for all citizens equally, and they are extremely sensitive to the concerns of large multistate employers. Furthermore, Governors understand the need for a system that is organized by the federal government and creates some uniform "rules of the game" across state lines to ensure portability. It is for these reasons that the NGA supports a strong federal framework that includes:

- The enactment of federal legislation to limit medical underwriting and minimize the variation in rates that different individuals and groups are charged. But states should continue to enforce insurance regulations.
- A core benefits package.
- · Federal malpractice guidelines for states will follow.
- · Changes in federal antitrust legislation.
- · Medical outcome and quality information standards.
- Administrative streamlining.

Not only are these elements of a strong federal framework they also preempt state authority in a number of important areas. Nevertheless, they are necessary to develop an efficient delivery system for health care. State flexibility is the other major component necessary to develop an efficient system. States need to have the flexibility to administer on a day-to-day basis any system that is eventually enacted within this federal framework. This means flexibility in designing, regulating, and overseeing the regional alliances and accountable health plans. It also means flexibility in administering the Medicaid and Medicare programs that are not fully integrated into the alliances. Under virtually any national health reform scenario, there are advantages of a state-based system.

- States are large enough to gain the economies of scale and yet small enough to tailor the system to the unique needs and cultures of individual states.
- If Congress adopts a new system that will require us to move into uncharted waters, it is
  critical to allow for state innovation and experimentation to design the most efficient and
  effective systems, and to allow for mid-course corrections and adjustments without seeking
  federal waivers or changes in federal legislation.
- Given that the implementation of a new health care system will take a minimum of three to
  five years, it is critical that a sustained commitment to support health care reform be
  maintained at the grassroots level. Allowing state flexibility to accommodate and adjust to
  local concerns will help maintain that commitment.

- States already have significant experience in administering health care programs, such as
  Medicaid and state employees health care, and states have a strong role regulating
  insurance and health care providers. It is important to build on this expertise and not have
  the federal government duplicate state responsibilities.
- Delivery systems differ dramatically from state to state, and states are at different points of readiness.

We would like to note, however, that while there is significant agreement among the Governors on the state role in national health reform, we do not agree on all aspects of health care reform. Most notable among these issues is the cost and financing of the new system and the mandatory nature of the alliances.

## The Governors' Reaction to the President's Health Security Act

Like most Americans, the Governors give high marks to the President for putting health care reform at the top of our national agenda. The Governors also are appreciative that the President has proposed a state-based system. There are a number of federal-state issues in the Clinton health care plan that the Governors' policy supports, while there are others that are not supported by existing policy.

Alliances and Accountable Health Plans. The Governors support the states' discretion on the number and regional boundaries of alliances. This will enable individual states to consider how its provider community and local governments are organized. The Governors support such latitude, but still have some questions about one aspect of this provision. The act does not permit metropolitan statistical areas to be divided into different alliances. As we understand it, the policy was designed to preclude discriminatory practices in drawing alliance boundaries. We support the antidiscriminatory language in the act and, if necessary, would support stronger language to give states the broader flexibility at issue. However, at the very least, there should be a waiver provision to allow the division of metropolitan statistical areas. Our concern is that it may be important in some states to draw boundaries that include rural areas with a part of the SMSA. Also, in some areas it may be important to accommodate alliances that cross state boundaries. This may increase the quality of care that is available in rural areas. Finally, the Governors support the flexibility to decide the legal entity governing the alliance (i.e., state agency, quasi-governmental agency, or private nonprofit organization).

Although few states will likely pursue the single-payer system, the Governors support the flexibility to have this option as described in the act with one modification. The act would require

the single-payer system to be operated by the state or a designated agency of the state. The Governors prefer to be able to contract out all or parts of a state's operation to the private sector and would like the legislative language to specifically allow this option. Governors also support additional flexibility to pursue alternate reform so long as goals of access, quality, and cost containment can be met.

The Governors support the authority vested in states to certify accountable health plans (AHPs), as well as to oversee the audits and guarantee funds. States already have considerable experience in this area due to the traditional role as regulators of insurance. It is critical that states have authority over both the alliances and the AHPs to ensure a cost-effective system.

While giving state flexibility in the establishment and administration of health alliances and AHPs, the legislative text confuses lines of authority between the federal and state governments by giving both the federal government and states some direct oversight and regulatory control over these entities. This could dilute accountability and may hurt the administrative efficiency of the system. Although the federal government has a legitimate interest in the efficient and effective operation of alliances and AHPs, the interest is best expressed through direct oversight of state governments, which can then regulate and oversee alliances and plans. We suggest that the federal government provide appropriate general guidelines rather than direct oversight.

While many Governors may differ on the need for setting fee-for-service rates, we appreciate the ability for states to set rates for the entire state or to have them vest this authority in regional alliances, as appropriate.

Finally, there is some concern about the responsibility of states to ensure adequate access to a choice of health plans, as described in the act. The language calls not only for choice, but also for access to plans at or below the weighted average premium "to the maximum extent practicable." The availability of plans will, to some extent, be determined by the premium budget assigned to the alliance and the number of AHPs that choose to bid within that budget cap. Because states will have no control over the budget that will be set nationally, states may not have the tools to ensure choice. Moreover, the act stipulates a right to enforce state responsibilities through 42 U.S.C. 1983 that is quite onerous. Giving individuals the right to sue states is a serious issue that will be vigorously opposed by Governors.

Finally, it appears that states are ultimately responsible to ensure that individuals have access to health care. Governors are very concerned that this provision will evolve into states having financial responsibility in the event of solvency problems for AHPs or if the federal

government's contribution reaches the enacted cap. States also have some fears that costs will be shifted to states or that benefits will be increased without additional federal funds.

Premium Caps. Governors are committed to meaningful cost containment that will bring the rate of growth in health care spending in line with the rate of growth in the federal economy. The Governors' policy supports budget targets in the early years of national reform, rather than immediate enforceable premium (budget) caps as detailed in the Health Security Act. Although the cap is determined and enforced by the federal government, the impact on states may be direct. If the federal government fails to set reasonable limits in the first several years, states may be left with the responsibility for correcting the damage done to providers, networks, and the availability of health care. The Governors urge caution in setting premium caps in the early years of health reform. While urging caution, the Governors do support the provision in the act that gives financial incentives to states to try to bring the alliance spending in under the budget. Without this incentive, one can expect that each alliance would negotiate premiums that are equal to the premium cap set by the National Health Board.

Transition to the New System. States may begin implementing the new system as early as January 1, 1996, with all states participating within two years. Although this deadline is somewhat ambitious, Governors believe that it can be met with the additional planning and start-up funds detailed in the legislative text. In fact, some states would prefer to begin operating a national system before the 1996 start date and will be seeking authority to do so.

Currently, a number of states are establishing mandatory or voluntary alliances, and others will be considering such legislation next year. In addition, states have undertaken insurance reforms, budgeting, integration of public and private programs, and other initiatives consistent with the President's proposal. These states will serve as laboratories for the President's approach, and other states will be able to benefit from their experiences. Essentially, the two-year window will allow states such as Florida, Hawaii, Minnesota, Oregon, Vermont, and Washington to implement early, since many of them already have enacted major health care reform. Similarly, it will give other states more time to implement. It is important to have the planning and start-up funds in the proposed legislation. States will have strong incentive to implement early since they will receive low-income and small business subsidies when they implement the new system.

New Community-Based Long-Term Care Program. The act creates a new communitybased long-term care program for persons with significant functional impairments. The Governors support community-based alternatives to institutional care, and the act has several provisions, including this one, consistent with that position. The Governors support the fact that states are given substantial flexibility, that community-based long-term care is not an individual entitlement program, and that this is an optional program. The one concern is that federal financial participation, though significant, is capped, while the state financial exposure may not be.

#### **Potential Economic Impacts**

In evaluating the potential economic impacts of the President's or other health care reform proposals, it is critical to differentiate between long- and short-run impacts.

Long-run Impacts. Any proposal that significantly reduces the rate of increase in health care costs will have a major positive long-run economic impact. This is because health care costs are virtually bankrupting all three levels of government and may be creating a drag on United States competitiveness.

- In 1986, Medicaid was only 10 percent of state budgets; in 1993, it has grown to about 17 percent, and is likely to approximate 25 percent by the late-1990s if current growth rates continue. Medicaid grew about 30 percent per year in 1991 and 1992. More state money is now spent on Medicaid than the 11 percent spent on higher education, and within a couple of years it will be more than the 21 percent spent on all elementary and secondary education.
- In 1992, the federal government spent almost \$200 billion on Medicare and Medicaid.

  These are the only programs in the budget that are projected to increase dramatically over
  the next decade. By the year 2003, these two programs will cost \$626 billion.

  Alternatively stated, the percentage of Gross National Product in these two programs will
  increase from 3.5 percent in 1992 to 6.2 percent by 2003.
- Counties and other local governments also have been hit hard by health care cost increases
  not only for their employees, but by the fact that local government has often been the
  provider of last resort.

Dramatically lowering the rate of increase of health care costs will allow governments at all levels to change priorities, reduce taxes, and provide more funding for both human and physical capital. This means more funding for education and training, as well as roads, bridges, ports, and other types of infrastructure. Over time, such increases in public investment should help increase productivity, create jobs, and increase real income.

Not only will decreasing the rate of growth in health care costs help all levels of government, it should have a similar impact on the private sector. Cost reduction will likely play out in two ways. First, firms will have higher profits that could be used for new capital investment, which would help increase productivity and real income. Second, it would be reflected in a lower cost of goods produced by U.S. firms. This should benefit U.S. consumers, and make United States goods comparatively cheaper in the international market, which should further stimulate the growth in the U.S. economy.

Short-run Impacts. While the long-term impact is positive, there is considerable uncertainty about the potential short-run impacts. The potential adjustments could take the following forms.

National Impacts. The health care industry that has created one out of every six jobs in the United States over the last ten years. As the growth in health care spending slows, so will the industry's ability to create new jobs. In addition to this slowing of the rate of job creation, there will be some other negative economic impacts. First, there may be some negative impact on the insurance industry due to a reduction in the fee-for-service business. Second, there may be a negative impact on some small businesses that do not now provide health coverage because of the mandate to pay health care benefits. On the other hand, there will be some positive economic impacts due to the fact that some 37 million people who do not currently have health insurance will become insured. There will also be some positive impact from capping the cost of health care for many firms and governments. The net impact on employment and income is difficult to determine at this time.

Impacts Within a State. Currently, we have very low hospital utilization and competition may force closure of some hospitals, probably in suburban and possibly in rural areas. This also may require new investments in clinics and other facilities in urban and, possibly, rural areas. While such an adjustment may be necessary it could cause some dislocation during the transition period in a number of states.

Impacts Across States. The Clinton plan as introduced, as well as alternative reform bills, have the potential for distributional impacts across states. While it is very difficult to quantify the various impacts, the following points may be important:

States that will have the largest number of uninsured, primarily the unemployed, after the
employer mandate is implemented will gain since they will be subsidized by the federal
government.

- States that have a high percentage of their populations over 65 and receiving Medicare, as
  well as those over 50 who are pensioners, will gain since there will be new federally paid
  drug benefits and subsidies for these individuals.
- States that have expensive health care costs relative to wages will gain since the 7.9
   percent caps will provide a federal subsidy to firms over the cap.
- States that have a disproportionate share of small business that do not currently provide
  health insurance will lose. However, the exact impact is complicated since it depends on
  the average wage as well as average number of employees in small firms.

The collective impact is difficult to quantify. However, it may depend substantially on the following:

- The underlying strength of the economy when health care reform is implemented. If
  economic growth is robust, then any potential short-run adjustments would be minimal.
  On the other hand, if the economy is fragile, the adjustment may be more difficult.
- The length of the transition period. In general, the longer the phase-in the more limited the short-run economic adjustment. However, the faster that the growth rate of health care costs is restrained, the more positive the impact.
- 3. The flexibility for states and the private sector to make adjustments. The greater the flexibility for states and the private sector to make adjustments during the implementation stage, the greater the possibility of avoiding short-run adjustments. The more rigid the system, the greater the potential for negative economic impacts.
- The amount of slack in the health care system. If there is substantial inefficiency in the current health care system, then the adjustment will be relatively smoother.
- 5. The effectiveness of global budgets. If global budgets are too tight or there is a misallocation of spending across alliances, then there may be some short-run economic dislocations. If, on the other hand, budgets work effectively, then costs will come down quickly with a positive impact.

Mr. Chairman, we would be very happy to answer any questions.

#### Additional Remarks for Governor Waihee

In addition to the testimony I have provided on the part of all the nation's Governors, there is a special perspective to share as the Governor of the state which has acted first and gone the farthest toward achieving universal health care.

First, I can emphatically say that an employer mandate need not hurt the economy. Hawaii has impressive economic evidence to show that employment, business failures and general growth in areas such as the service industry sector have not been affected. I would suggest, however, that an employer mandate be kept simple, and flexible, as ours is. This flexibility has allowed our system to adapt without undue government interference. Instead of a subsidy for our employers, we believe the mechanism we have used, a Premium Supplementation Fund, targets small business employers in need and results in the lowest governmental cost. We recommend it for your consideration.

Second, I have recently submitted a Health Alliance Bill to our state legislature. Our proposed Alliance is structured to meet national goals with a mechanism tailored to our state's own health care system. Similarly, I would recommend that the Alliance piece in federal legislation give states the flexibility to develop alliances to meet their needs as long as they adhere to well-defined federal objectives. An Alliance structured to serve New York or California, or indeed Hawaii, may not meet the needs of other states.

Third, as Governor from a low-cost state, I have concerns about the proposed premium caps. While inefficient states will be able to cut "fat" and waste, we will not have much to cut. Any such cuts should have significant input from states such as ours and should be set based upon state-based data collection systems. Otherwise, low-cost states such as Hawaii will be penalized for costs attributable to such uncontrollable factors as demographic changes.

Fourth, we like and applaud the directions the administration's proposal is taking Medicaid.

Our own Medicaid 1115 demonstration waiver for Hawaii's Health QUEST program is formulated around the same principle. We do, however, have concerns that the vestiges of Medicaid (e.g.,

Qualified Medicare Beneficiaries) may cause undue administrative burden for Hawaii and other states. The administrative requirements of running small "side" programs of this nature outweigh the benefits. We would be grateful, therefore, if these could be run directly by the federal government.

Finally, states need flexibility to make health reform happen. Hawaii's own health reforms have been written broadly, without great detail, because we realized we were working with many unknowns. Flexibility which emphasizes <u>results over process</u> would be especially effective in making the reforms the nation enacts into statute work in the real world.

Many thanks for the opportunity to provide input into this process. We look forward to working closely with you to provide all Americans the health care they need and deserve.

#### PREPARED STATEMENT OF CARMEN BUELL

MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THE COMMITTEE:

My name is Carmen Buell. I am a member of the Massachusetts House of Representatives and serve as the House Chair of the Joint Committee on Health Care.

I would like to thank the Chairman, my own senior senator from Massachusetts, Senator Kennedy, for inviting me to testify today on the states' role in health care reform. Over the years, it has been Senator Kennedy who has consistently and compassionately called for national health care reform and the people of Massachusetts are thankful for his leadership.

I AM ALSO TESTIFYING IN SUPPORT OF THE POLICIES AND POSITIONS TAKEN BY THE NATIONAL CONFERENCE OF STATE LEGISLATURES (NCSL). I AM SUBMITTING TO THE COMMITTEE NCSL'S PRINCIPLES FOR HEALTH CARE REFORM AND A DOCUMENT OUTLINING NCSL'S POSITION ON VARIOUS MEDICAID ISSUES RELATIVE TO NATIONAL HEALTH CARE REFORM.

RECENTLY, THE MASSACHUSETTS HOSPITAL ASSOCIATION (MHA) CONDUCTED A SURVEY OF MASSACHUSETTS RESIDENTS. THE SURVEY WAS DESIGNED TO DETERMINE THE LEVEL OF SUPPORT FOR PRESIDENT CLINTON'S HEALTH SECURITY ACT AND FOR THE IMPLEMENTATION OF CHAPTER 23—THE MASSACHUSETTS UNIVERSAL COVERAGE LAW THAT INCLUDES AN EMPLOYER MANDATE.

I BELIEVE THE RESULTS OFFER A COMPELLING AND DRAMATIC TESTIMONIAL TO THE NEED TO PROCEED WITH HEALTH CARE REFORM.

SIXTY-TWO PERCENT OF THE RESPONDENTS -- NEARLY TWO-THIRDS OF THOSE SURVEYED BY THE MHA -- EXPRESSED APPROVAL FOR THE CLINTON PLAN. MORE THAN SIXTY-SEVEN PERCENT INDICATED THAT THEY BELIEVE MASSACHUSETTS SHOULD PROCEED WITH IMPLEMENTATION OF ITS EMPLOYER MANDATE.

These are strong statistics, and I am encouraged by them. But I found some of the other findings more striking — and perhaps even more telling. I was particularly taken with the results that pertain to the attitudes people have about their own health care situation.

THE RESPONSES PROVIDE CONVINCING EVIDENCE THAT HEALTH CARE — OR MORE ACCURATELY THE FEAR OF LOSING HEALTH CARE — IS CASTING A PALL OVER THE LIVES OF A SIGNIFICANT PORTION OF THE MASSACHUSETTS' POPULACE. AN UNEASINESS HAS DEVELOPED IN OUR STATE — AND I BELIEVE IN OTHER STATES ACROSS THE NATION — OVER THE SPECTER OF BEING WITHOUT HEALTH CARE INSURANCE BENEFITS.

RECENT DATA SHOW THAT RATES OF UNINSURANCE ARE INCREASING, PRIMARILY AS A RESULT OF DECLINING EMPLOYER-BASED COVERAGE. IN 1989, EMPLOYERS SPONSORED 65.4% OF THE NON-ELDERLY POPULATION. IN 1992, THEY COVERED 62.5%. THE PRESENT SYSTEM IS LEADING US TOWARD A WORSENING SITUATION. THESE NUMBERS SUPPORT THE INSECURITIES EXPRESSED IN THE MASSACHUSETTS HOSPITAL ASSOCIATION SURVEY.

HEALTH CARE HORROR STORIES ABOUND. WE'VE ALL HEARD THEM. EVERYBODY IS ACQUAINTED WITH SOMEONE — A FAMILY MEMBER, A NEIGHBOR OR WORK COLLEAGUE — WHOSE LIFE HAS BEEN THROWN INTO SHAMBLES BECAUSE HE OR SHE GOT SICK AND DIDN'T HAVE ADEQUATE HEALTH INSURANCE. WE ALL KNOW PEOPLE WHOSE HEALTH OR FINANCES — OR IN SOME CASES BOTH — HAVE FALLEN VICTIM TO OUR FAILING SYSTEM. OFTEN TIMES, THE SYSTEM FAILS BECAUSE OUR HEALTH AND FINANCIAL SECURITY IS LINKED TO A JOB.

NO ONE IN THIS COUNTRY HAS THE SECURITY OF KNOWING HIS OR HER HEALTH INSURANCE WILL BE THERE WHEN IT IS TRULY NEEDED. LOSS OF A JOB OR A CATASTROPHIC ILLNESS CAN ERASE A FAMILY'S FINANCIAL FUTURE INSTANTLY. PRE-EXISTING CONDITION EXCLUSIONS, A LACK OF PORTABILITY AND UNAFFORDABLE PREMIUMS CAUSE THIS INSECURITY.

BUT AGAINST THIS BACKGROUND OF UNCERTAINTY THERE IS A GROWING CONSENSUS, IN MASSACHUSETTS AND ACROSS THE UNITED STATES, THAT IT IS TIME FOR THOSE OF US IN THE STATE LEGISLATURES AND FOR CONGRESS TO ACT ON HEALTH CARE REFORM.

In preparing today's testimony on the role of states in health care reform, I tried to look at the big picture as I selected, organized, and set out to articulate what I consider the most important points in the debate.

First of all, I want to talk about federal-state partnerships — and endeavor to elevate the concept of federalism to the forefront of health care reform. My colleagues in Massachusetts — and legislators in many other states as well — feel very strongly about the importance of developing a health care system that has as its cornerstone an equitable working relationship between states and the federal government.

AS OUR DEARLY DEPARTED TIP O'NEIL REMINDED US AGAIN AND AGAIN, ALL POLITICS IS LOCAL. THAT'S ESPECIALLY TRUE OF HEALTH CARE, WHERE THE ISSUES ARE TRULY LOCAL. THE POLITICS OF HEALTH CARE ARE INTIMATELY LINKED TO NEIGHBORHOOD, LOCAL PRACTITIONERS WHO ARE DEDICATED TO THE COMMUNITIES IN WHICH THEY WORK AND LOCAL INSTITUTIONS WITH HISTORIC TIES TO THE COMMUNITY. THOSE LOCAL PLAYERS MAKE UP THE DELIVERY NETWORKS THAT ARE EVOLVING AROUND US SO QUICKLY. LOCAL HEALTH CARE DYNAMICS EVEN AFFECT NATIONAL UNIONS AND MULTI-STATE CORPORATIONS.

THE ARGUMENT FOR A STRONG FEDERALISM-PARTNERSHIP CONCEPT IS FURTHER ADVANCED WHEN ONE CONSIDERS THE BREADTH AND DEPTH OF HEALTH CARE KNOWLEDGE AND EXPERIENCE THAT EXISTS IN OUR STATES. PLAIN AND SIMPLE, STATES KNOW HEALTH CARE. THEY ARE INVOLVED IN EVERY ASPECT OF IT — IN PUBLIC HEALTH PROGRAMS, HEALTH CARE FINANCING, POLICY AND REGULATION. IN A SENSE, STATES ARE HEALTH CARE LABORATORIES WHERE PROGRAMS, NEW IDEAS AND INITIATIVES ARE HATCHED, NURTURED, TESTED, RE-TESTED, REFINED, FUNDED, IMPLEMENTED AND INSTITUTIONALIZED.

STRONG STATE-FEDERAL PARTNERSHIPS ARE ALSO IMPORTANT BECAUSE ENORMOUS DIFFERENCES EXIST BETWEEN STATES — POLITICALLY, INSTITUTIONALLY AND DEMOGRAPHICALLY. FOR THIS REASON, I BELIEVE STATES MUST BE GIVEN CONSIDERABLE FLEXIBILITY IF HEALTH CARE REFORM IS TO BE EFFECTIVE. FLEXIBILITY WILL BE NECESSARY IN THE FOLLOWING AREAS:

- 1) DEFINING THE ROLES OF THE MEDICAID AND MEDICARE PROGRAMS IN REFORM;
- THE DESIGN OF MULTI-PAYER SYSTEMS; FSPECIALLY WITH RESPECT TO PROVISIONS FOR RISK ADJUSTMENT, SUBSIDIES AND MANDATES;

- IMPROVING ACCESS TO CARE FOR RURAL, URBAN AND INNER CITY POPULATIONS.
   THIS INCLUDES THE IDENTIFICATION AND DESIGNATION OF ESSENTIAL COMMUNITY PROVIDERS;
- 4) THE WAY STATES ARE ALLOWED TO APPROACH COST CONTAINMENT EFFORTS AND FINANCING MECHANISMS;
- 5) EXPERIMENTING WITH REGIONAL APPROACHES TO IMPLEMENTING REFORM. LAST WEEKEND I MET WITH MORE THAN 25 STATE LEGISLATORS FROM ACROSS NEW ENGLAND. WE AGREED THERE ARE SIGNIFICANT BENEFITS TO CRAFTING HEALTH CARE POLICY AS A BLOC, AGREEING TO COMMON FINANCING MECHANISM, ADOPTING CERTIFICATE OF NEED REGULATIONS THAT ARE CONSISTENT ACROSS STATE BORDERS AND DISCOURAGING THE CREATION OF A DUPLICATE DELIVERY SYSTEM.

FOR THE REASONS I'VE OUTLINED, IT'S CLEAR TO ME THAT ANY PLAN EMERGING FROM CONGRESS MUST EMBRACE AND BUILD ON THE CONCEPTS OF FEDERALISM AND PARTNERSHIP WITH THE STATES.

The second point I would like to make concerning the role of the states in health care reform is the necessity of guaranteeing universal coverage.

The swirl of debate on health care reform has produced two distinct schools of thought: Some espouse the theory that we should take steps to contain health care costs before undertaking efforts to provide universal coverage.

OTHERS MAINTAIN THAT GUARANTEED NATIONAL HEALTH INSURANCE MUST COME FIRST BECAUSE WE CANNOT ACHIEVE TRUE COST CONTAINMENT WITHOUT FIRST ENSURING UNIVERSAL COVERAGE.

I fall uncategorically into the second camp. From my perspective, cost containment and universal coverage are inextricably linked and interdependent. If we only deal with cost containment, we will inevitably see diminished access for certain groups. The easiest way to contain costs is to exclude people from the system. As long as we allow exclusionary practices as a cost containment option we will not sufficiently pressure the system to produce savings. Also, history has shown us that piecemeal efforts to contain costs in one sector or for one payer only cause costs to balloon out in other areas.

THEREFORE, I URGE THE CONGRESS TO PROVIDE A MECHANISM FOR UNIVERSAL INSURANCE COVERAGE. A RECENT REPORT BY THE NATIONAL COMMISSION ON THE STATE AND LOCAL PUBLIC SERVICE ENTITLED "FRUSTRATED FEDERALISM: RX FOR STATE AND LOCAL HEALTH CARE REFORM" CONCLUDED THAT STATES CANNOT TRULY MEET THE NEEDS OF UNINSURED OR UNDER-INSURED PEOPLE. THE ONLY WAY TO PROVIDE THAT COVERAGE, THE COMMISSION SAID, IS THROUGH UNIVERSAL INSURANCE COVERAGE WITH A NATIONALLY DEFINED STANDARD BENEFITS PACKAGE.

POLITICALLY AND ECONOMICALLY IT WILL BE EXTREMELY DIFFICULT FOR STATES TO MOVE TOWARD UNIVERSAL COVERAGE. YET THE FACT THAT SO MANY ARE TRYING SHOWS OUR DEDICATION AND COMMITMENT TO THIS IDEAL. ASSENT UNIVERSAL COVERAGE FOR A STANDARD BENEFITS PACKAGE, INDIVIDUALS WILL CONTINUE TO RELY ON STATE FUNDED INSURANCE PROGRAMS AND FREE CARE. WITHOUT UNIVERSAL COVERAGE, WE WILL NEVER BE ABLE TO MEASURE TRUE COST, LET ALONE CONTROL IT. WITHOUT UNIVERSAL COVERAGE, WE WON'T BE ABLE TO DEVELOP A RATIONAL INSURANCE SYSTEM BECAUSE THERE WILL BE PERFETUAL COSTS SHIFTING, RISK AVERSION AND OTHER PERVERSE INCENTIVES. I AGREE WITH NCSL AND THE PRESIDENT -- THE FIRST AND FOREMOST GOAL OF ANY REFORM PACKAGE MUST BE TO PROVIDE HEALTH CARE COVERAGE FOR ALL.

UNIVERSAL COVERAGE IS IMPORTANT FOR ANOTHER REASON — IT IS NEEDED TO RELIEVE THE ENORMOUS FINANCIAL STRESS STATES NOW EXPERIENCE FROM THE COSTS OF COVERING UNINSURED AND UNDER-INSURED POPULATIONS. TO THEIR CREDIT, STATES HAVE DEVELOPED A

VARIETY OF PROGRAMS TO MEET THE NEEDS OF PEOPLE WITHOUT INSURANCE AND WITHOUT ACCESS TO BASIC PRIMARY CARE AND PREVENTIVE SERVICES. IN MASSACHUSETTS WE HAVE PUBLIC PROGRAMS FOR UNINSURED CHILDREN, THE WORKING DISABLED, THE UNEMPLOYED AND A FREE CARE POOL TO REIMBURSE HOSPITALS AND COMMUNITY HEALTH CENTERS.

WE SPEND MORE THAN \$570 MILLION FOR THESE HEALTH SERVICES AND HEALTH PRODUCTS FOR THE UNINSURED AND UNDER-INSURED. OBVIOUSLY, THESE RESOURCES COULD BE USED ELSEWHERE — FOR JOB GENERATION; EDUCATION; AID TO CITIES AND TOWNS; PUBLIC HEALTH PROGRAMS; OR FOR ANY NUMBER OF OTHER CRITICAL PROGRAMS.

STATES LIKE MASSACHUSEITS ARE PROUD OF THE COMMITMENT WE HAVE MADE TO PROVIDE HEALTH CARE TO THE UNDER-SERVED. BUT WE ARE CONCERNED ABOUT CONTINUING DOWN A PATH THAT SEEMS EACH FISCAL YEAR TO LEAVE US AT A DIFFICULT CROSSROAD. THE CHOICES BETWEEN FUNDING HEALTH PROGRAMS AND WIELDING THE BUDGET AX ELSEWHERE GET HARDER AND HARDER. THIS POINT IS DOCUMENTED IN THE NATIONAL COMMISSION ON THE STATE AND LOCAL PUBLIC SERVICE REPORT, WHICH SAYS THAT STATES LACK THE FISCAL CAPACITY OR REGULATORY AUTHORITY TO ENACT UNIVERSAL COVERAGE WITHOUT SIPHONING FUNDS FROM OTHER WORTHY CAUSES.

STATES NEED RELIEF FROM THESE FINANCIAL BURDENS -- AND RELIEF WILL ONLY COME WHEN CONGRESS, WITH A STANDARD BENEFITS PACKAGE, ENACTS FEDERALLY GUARANTEED HEALTH INSURANCE FOR ALL.

UNCOMPENSATED CARE PROVIDED IN ACUTE HOSPITALS-	\$480 MILLION
Uncompensated care provided in free-standing community health centers (n=34)	\$8.6 MILLION
MEDICAL SECURITY PROGRAM (COVERAGE FOR UNEMPLOYED UNINSURED)	\$48 MILLION
HEALTHY KIDS PROGRAM (COVERAGE FOR UNINSURED CHILDREN AGES 1-12)	\$12 MILLION
COMMON HEALTH PROGRAM (COVERAGE FOR UNINSURED DISABLED)	\$18 MILLION
CENTER CARE PROGRAM (COMMUNITY HEALTH CENTER CARE FOR UNINSURED)	\$5 MILLION
HEALTH CARE FOR THE HOMELESS (GREATER BOSTON PROGRAM)	\$.3 MILLION
DPH Breast Cancer Program	\$4.1 MILLION

OTHER IMPORTANT ISSUES REGARDING THE STATES' ROLE IN HEALTH CARE REFORM INVOLVE ERISA AND MEDICAID. I WON'T DWELL ON THE MEDICAID ISSUE FOR TWO REASONS:

- 1) THEY ARE DETAILED IN THE NCSL DOCUMENTS I'VE SUBMITTED TO THE COMMITTEE; AND
- 2) THE PLEAS YOU HEAR FROM GOVERNORS ABOUT THE NEED FOR FLEXIBILITY AND CHANGES IN MEDICAID ARE ECHOED BY STATE LEGISLATURES ACROSS THE COUNTRY.

LET ME FOCUS THEN ON THE ISSUE OF ERISA. AS I SAID EARLIER IN MY TESTIMONY, STATES ARE THE LABORATORIES FOR HEALTH CARE POLICY. IT IS LARGELY AT THE STATE LEVEL WHERE PROGRAMS AND NEW IDEAS IN HEALTH CARE ARE TESTED AND IMPLEMENTED. STATES RELISH THAT ROLE, YET FIND THEMSELVES — ESPECIALLY NOW AS THEIR EFFORTS AT COMPREHENSIVE SYSTEMS REFORM ACCELERATE — RUNNING UP AGAINST BARRIERS IMPOSED BY ERISA. AS A LEGISLATOR ATTEMPTING TO CRAFT COMPREHENSIVE HEALTH CARE REFORM IN MY OWN STATE, I LIKEN IT TO SMASHING INTO A BRICK WALL.

THE IMPENETRABILITY AND INFLEXIBILITY OF ERISA HAS ALREADY STIFLED INNOVATION AT THE STATE LEVEL IN DESIGNING UNIVERSAL COVERAGE MECHANISMS. ALL OF THE LEADING STATE BASED REFORM EFFORTS INCLUDE THE PRESUMPTION OF AN ERISA WAIVER.

I WANT TO HIGHLIGHT FOUR SPECIFIC OBSTACLES STATES FACE AS A CONSEQUENCE OF ERISA.

- 1) STATES CANNOT ASK SELF-INSURED EMPLOYERS TO PAY PREMIUM CONTRIBUTIONS FOR HEALTH BENEFITS IN A MULTI-PAYER OR SINGLE-PAYER SYSTEM. THIS IN ESSENCE PREVENTS STATES FROM FUNDING UNIVERSAL COVERAGE FOR STATE RESIDENTS IN A BROAD-BASED, EQUITABLE MANNER. IN SHORT, ERISA PRECLUDES STATES FROM RAISING REVENUES FOR HEALTH BENEFITS FROM SELF-INSURED EMPLOYERS.
- STATES CANNOT ASK SELF-INSURED EMPLOYERS FOR HEALTH CARE INFORMATION.
  AS A RESULT, IT'S NOT POSSIBLE TO COLLECT HEALTH CARE DATA FROM THESE
  EMPLOYERS.
- STATES CANNOT ASK SELF-ENSURED EMPLOYERS TO PROVIDE A COMMON, STANDARD BENEFIT PACKAGE FOR THEIR WORKERS.
- 4) STATES CANNOT ASK SELF-INSURED EMPLOYERS TO ABIDE BY THE INSURANCE MARKET REFORMS OF GUARANTEED INSURANCE AND GUARANTEED RENEWAL.

  THAT RESTRICTION IS ESPECIALLY DAMAGING TO HIGH-RISK EMPLOYEES SUCH AS AIDS PATIENTS.

CLEARLY, THE FALLOUT FROM ERISA IS MASSIVE AND WIDESPREAD. FOR STATES ACROSS THE NATION, ERISA IS AN IMPEDIMENT THAT SERIOUSLY HINDERS THEIR EFFORTS AT MEANINGFUL REFORM AND AT MEETING THE HEALTH NEEDS OF ALL THEIR CITIZENS.

THE MAGNITUDE OF THE DILEMMA FACING STATES AS A RESULT OF ERISA CANNOT BE OVERSTATED. STATES NEED A SOLUTION TO THIS FAR-REACHING AND PERPLEXING PROBLEM — AND I WANT TO SAY THAT AS STRONGLY AND PERSUASIVELY AS POSSIBLE.

IN MY MIND, THE ULTIMATE FIX LIES IN THE PASSAGE OF NATIONAL HEALTH REFORM — IN A PLAN THAT PROVIDES UNIVERSAL COVERAGE FOR A NATIONALLY DEFINED STANDARD BENEFIT PACKAGE. IN THE ABSENCE OF THAT TYPE OF COMPREHENSIVE REFORM, CONGRESS MUST AMEND ERISA, THEREBY PERMITTING STATES TO ENACT MECHANISMS THAT GUARANTEE COVERAGE FOR ALL STATE RESIDENTS; FINANCE THE PURCHASE OF A STATE-ENACTED STANDARD BENEFITS PACKAGE; AND REGULATE COMPANIES THAT SELF-INSURE.

In conclusion, I'll summarize my three major points with respect to the states' role in health care reform.

- FEDERAL-STATE PARTNERSHIPS. THE IMPORTANCE OF MAKING THIS CONCEPT AN
  ESSENTIAL ELEMENT OF HEALTH REFORM IS CRITICAL FROM THE STATE
  PERSPECTIVE.
- 2) A NATIONAL GUARANTEE OF UNIVERSAL COVERAGE THROUGH A STANDARD BENEFIT PACKAGE. WITHOUT THAT GUARANTEE, WE'LL BE UNABLE TO MEET THE NEEDS OF THE UNINSURED AND UNDER-INSURED; UNABLE TO SUCCESSFULLY CONTROL HEALTH CARE COSTS; AND UNABLE TO EASE THE FINANCIAL BURDEN ON STATES.
- 3) FLEXIBILITY WITH ERISA. THE DIFFICULTY OF DEALING EFFECTIVELY WITH REFORM ISSUES RELATED TO SELF-INSURED EMPLOYERS CANNOT BE OVERCOME UNLESS CONGRESS APPROVES LEGISLATION PROVIDING A STANDARD NATIONAL BENEFIT PACKAGE OR AMENDS ERISA TO ADDRESS STATE CONCERNS.

MEMBERS OF STATE LEGISLATURES ARE LIKE MEMBERS OF CONGRESS. WE HAVE PROMISED TO MAKE THE WELL-BEING OF OUR CONSTITUENTS OUR HIGHEST PRIORITY. THE AMERICAN PEOPLE BELIEVE IN AND ARE GUIDED BY A BASIC SET OF FUNDAMENTAL VALUES. THEY LOVE THEIR FAMILIES. THE CARE ABOUT OTHER PEOPLE, THEIR COMMUNITIES AND THEIR NATION. THOSE BASIC NATIONAL VALUES — LOVE OF FAMILY, SECURITY AND COMPASSION FOR OTHERS — OUGHT TO BE OUR GUIDING PRINCIPLE IN THE HEALTH CARE REFORM DEBATE. THE FEDERAL GOVERNMENT MUST DECLARE THAT EVERY AMERICAN HAS THE RIGHT TO UNIVERSAL COVERAGE—WITH A COMPREHENSIVE ARRAY OF HEALTH BENEFITS AND A QUALITY DELIVERY SYSTEM. WITHIN THAT FRAMEWORK OF NATIONAL VALUES AND NATIONAL GUIDELINES, STATES MUST BE GIVEN THE FLEXIBILITY TO IMPLEMENT THAT POLICY IN WAYS THAT FIT THEIR INDIVIDUAL UNIQUE CIRCUMSTANCES AND NEEDS.

I APPRECIATE THE OPPORTUNITY TO SHARE MY VIEWS WITH YOU AND TO PRESENT DOCUMENTS FROM NCSL. I SPEAK ON BEHALF OF MY COLLEAGUES IN STATE LEGISLATURES ACROSS THE COUNTRY IN PLEDGING OUR COMMITMENT TO WORK WITH ALL OF YOU IN THE COMING MONTHS.

# **National Conference of State Legislatures**

# OFFICIAL POLICY

#### **HEALTH COMMITTEE**

## PRINCIPLES FOR HEALTH CARE REFORM

During the period in which the federal comprehensive plan is being developed and implemented, the federal government should adhere to the following principles. States should be afforded maximum flexibility to begin innovative reform of their health care delivery systems. The federal government must develop an expedited waiver process by which states can receive multi-year waivers of requirements under Medicaid, Medicare, ERISA and other federal laws to implement state enacted programs.

#### **ACCESS**

- NCSL supports universal coverage for all residents of the United States and its territories. Employers are the primary source of access to health care for most people. Policies for health care reform should encourage them to continue to provide health insurance coverage to their employees and their dependents. Individuals should have a choice of health plans and primary care providers.
- Ensure that rural communities have options including fee for service reimbursement and/or managed care.
- All individuals should be required to participate in the health care system. Reform policies should develop mechanisms for outreach and enrollment of all residents in health coverage. Coverage must include provisions for portability, coverage for pre-existing conditions, and a appropriate rating mechanism, including but not limited to, community rating.
- Public or private purchasing cooperatives and other innovative ventures should be encouraged to permit groups and individuals to negotiate for affordable health care coverage on the same basis as large groups.

#### COVERAGE

The federal government should establish a standard benefit package and should develop insurance guidelines and operating standards relating to that package and include a comprehensive array of benefits including and emphasizing preventive and primary health care services.

#### REGULATION

States should continue to regulate insurance, and regulation would include but not be limited to, supplemental coverage, self-insured and third party administered plans, METS, MEWA's accountable health plan, and HICP's to ensure that a standard health insurance program is available to all covered populations.

#### WORKERS COMPENSATION

Any proposed changes in coverage, responsibility, medical care delivery and payment methods in workers compensation incurred by changes in national health policy should be reviewed and approved by the states to assure core values such as broad coverage, safe and healthful workplaces, prompt and high quality health care, are preserved and neither liability nor the exclusive remedy doctrine should be attered.

#### FINANCING

- The source of funding should be progressive, broad-based, and have the potential for growth.
- State premium tax revenue should be preserved and held harmless.
- Unincorporated businesses should incur the same tax deductibility benefits as do other businesses.
- Financial support for the program should be shared by government, the private sector, and individuals, with all participating according to their ability to pay.
- If a national target for health care expenditures is established, states should have a role in negotiating such targets.
- States should share in any savings and the savings should be used by the state for public health programs.

#### **COST CONTAINMENT**

- Managed care should be emphasized and encouraged.
- Service reimbursement should emphasize a reimbursement, system which minimizes the disparity between primary care and specialized care. State reimbursement systems may be based upon fee for service reimbursement capitation, Resource Based Relative Value Systems (RBRVS), hourly rates or other negotiated fee schedules.
- States should be permitted to utilize the full range of cost containment strategies available to control cost, while at the same time maintaining quality. Health planning should be a key component of health care reform proposals developed at the state and federal level. The states, not the federal government, should regulate the allocation of advanced technology and capital expansion, within states and localities.
- Administrative simplification should be a key component in reducing costs and should include: (1) the development of uniform claims form; (2) the establishment of uniform codes; (3) electronic billing; and (4) computerized medical records and "smart cards" for medical records and medical history. Federal and state governments should share information; however, confidentiality of medical records and information shall be protected.
- Health care reform should include meaningful reform measures which eliminate incentives for providers to overtreat or practice defensive medicine without preempting state law.

#### QUALITY

- Quality assurance programs should be part of any national health care reform effort and may include: (1) improved peer review and implementation of disciplinary actions of health practitioners; and (2) incentives to states to enact alternative dispute resolution statutes.
- The federal government and the National Association of Insurance Commissioners should actively support outcomes and effectiveness research. The results of this research will assist in the development of practice parameters that can be used to develop appropriate standards of care and to help consumers evaluate health care services.
- The federal government and the National Association of Insurance Commissioners jointly should establish a standardized information base for the states so consumers would have comparable data on price, service and quality of health care services to use in selecting a plan or provider.

## MEDICAID

- Current Medicaid clients should be fully integrated into any comprehensive health care reform program. States would continue to contribute, on a matching funds basis, to the cost of providing care to low income individuals. States should be authorized to raise matching fund revenues according to state law, with minimal federal intrusion. States oppose a cap on federal medicaid matching funds, as caps will only increase cost shifting to states and the private sector.
- Long term care should continue to be jointly funded by the states and the federal government and administered by the states. Innovations should be explored to increase the cost effectiveness of and access to such programs, including a greater emphasis on home and community-based care.
- The federal government should work with the states to explore options that would change responsibilities between the states and the federal government regarding long term care.
- Health care coverage should not be linked to federal cash benefit programs such as Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI).

## **DELIVERY SYSTEM**

- o The federal and state governments must include incentives to encourage health professionals to practice in underserved and rural areas.
- The federal government should provide incentives for and allow states the flexibility to meet increasing demands for primary care practitioners by allowing states to develop innovative programs which retrain physician specialists, expand practice opportunities for nurse practitioners and other health personnel and to coordinate educational opportunities for medical professionals to achieve advanced training and graduate degrees.
- The federal government should support efforts to increase the numbers of minorities, women and disadvantaged individuals in the health professions, particularly as primary care practitioners.
- Community health centers, school clinics, public health clinics, family planning clinics and other community providers with proper standards and certification should be included in the network of providers that are eligible to provide services to individuals.
- The federal government should address the problems of international border health issues as they relate to communicable diseases. This should be addressed by a multi-national effort and or regional state compacts..

#### MEDICAID IN HEALTH CARE REFORM

HEALTH CARE REFORM PRESENTS A UNIQUE OPPORTUNITY TO FUNDAMENTALLY CHANGE THE WAY OUR NATION PROVIDES HEALTH CARE SERVICES TO LOW INCOME INDIVIDUALS AND THEIR FAMILIES. NCSL BELIEVES THAT A COMPREHENSIVE HEALTH CARE REFORM STRATEGY SHOULD:

- (1) PERMANENTLY SEPARATE THE ELIGIBILITY FOR HEALTH CARE COVERAGE FROM ELIGIBILITY FOR FEDERAL CASH ASSISTANCE PROGRAMS;
- (2) FULLY INTEGRATE THE ACUTE CARE PORTION OF MEDICAID INTO THE OVERALL REFORM EFFORT, PROVIDING EQUITY IN COVERAGE AND SIMPLIFYING ADMINISTRATION;
- (3) PROMOTE EQUITY BETWEEN STATES; AND MOST IMPORTANTLY;
- (4) AVOID BUILDING ON THE WEAKNESSES OF THE EXISTING MEDICAID PROGRAM.

BELOW IS A BRIEF ANALYSIS OF THE MEDICAID PROVISIONS OF PRESIDENT CLINTON'S HEALTH CARE REFORM PLAN.

## FULL INTEGRATION OF MEDICAID ACUTE CARE SERVICES

PRESIDENT CLINTON'S PROPOSAL WOULD FULLY INTEGRATE THE NONCASH MEDICAID RECIPIENTS INTO THE REFORMED HEALTH CARE SYSTEM AND PARTIALLY INTEGRATES INDIVIDUALS RECEIVING AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC) AND SUPPLEMENTAL SECURITY INCOME (SSI) INTO THE SYSTEM AS WELL. WHILE NCSL BELIEVES THIS IS MOVEMENT IN THE RIGHT DIRECTION, WE SUPPORT FULL INTEGRATION THAT WOULD INCLUDE CATEGORICALLY ELIGIBLE INDIVIDUALS.

#### SUPPLEMENTAL/RESIDUAL BENEFITS

Under the Administration proposal, noncash Medicaid recipients would lose eligibility for "residual" Medicaid coverage, and would have to obtain additional coverage in the same manner as other participants in the regional or corporate health alliances (ie. supplemental insurance or out-of-pocket expenditures). Individuals who are categorically eligible for Medicaid (AFDC and SSI recipients) would continue to be eligible for and states would be required to provide, residual Medicaid coverage. We are concerned about this requirement. This approach creates inequities in the new health care system. Similarly situated individuals would be eligible for different health care coverage and services based solely on their eligibility to receive federal cash assistance through AFDC or SSI. If the comprehensive, standard benefit package fails to provide adequate coverage for certain individuals, the eligibility for supplemental coverage should be standard and the financing should be clearly set out.

THERE ARE CERTAINLY MEDICAID OPTIONAL SERVICES THAT ARE EXTREMELY BENEFICIAL TO CURRENT MEDICAID RECIPIENTS. NCSL BELIEVES THAT WE NEED TO FOCUS ON IDENTIFYING SERVICES, NOT COVERED IN THE STANDARD BENEFIT PACKAGE, THAT ARE CRITICAL TO ENSURE PARTICIPATION OF LOW INCOME AND DISABLED INDIVIDUALS REGARDLESS OF THEIR SOURCE OF INCOME OR STATUS WITH RESPECT TO FEDERAL CASH ASSISTANCE PROGRAMS. THIS IS AN AREA WHERE STATES, IN CONCERT WITH LOCAL GOVERNMENTS, REGIONAL HEALTH ALLIANCES, HEALTH CARE PROVIDERS, LOW-INCOME AND DISABLED INDIVIDUALS, AND ACCOUNTABLE HEALTH PLANS, SHOULD WORK CLOSELY TOGETHER TO DEVELOP A WORKABLE SOLUTION. THIS APPROACH WOULD BE MORE IN THE SPIRIT OF THE ADMINISTRATION'S OVERALL REFORM STRATEGY THAT STRIVES TO ESTABLISH A LEVEL OF UNIFORMITY AND EQUITY WITHIN THE SYSTEM.

#### PROGRAM FOR CHILDREN WITH SPECIAL NEEDS

THE ADMINISTRATION HAS PROPOSED A NEW CAPPED ENTITLEMENT PROGRAM THAT WOULD PROVIDE MEDICALLY NECESSARY SERVICES, NOT INCLUDED IN THE STANDARD BENEFIT PACKAGE, TO CHILDREN IN CERTAIN LOW-INCOME HOUSEHOLDS. THE PROGRAM WOULD BE

100 PERCENT FEDERALLY FUNDED. STATES WOULD BE RESPONSIBLE FOR DETERMINING ELIGIBILITY. WE ARE CONCERNED ABOUT THE COMPLICATED ELIGIBILITY CRITERIA FOR THE CHILDREN'S PROGRAM. WE BELIEVE THAT THE PROGRAM WOULD BE EASIER TO ADMINISTER IF THE INCOME ELIGIBILITY LEVEL WAS STANDARD AND IF IT APPLIED TO ALL CHILDREN WITHIN AN ESTABLISHED INCOME ELIGIBILITY LEVEL. FINALLY, IF THE CHILDREN ARE TO BE ENTITLED TO THESE SUPPLEMENTAL BENEFITS, THE FEDERAL FUNDING SHOULD NOT BE CAPPED.

#### MAINTENANCE OF EFFORT

NCSL does not oppose maintenance of effort requirements, however; it is critical that the requirements are fair. We oppose being locked into "optional" programs currently in place and we oppose maintenance of effort requirements that penalize states that have made a concerted effort to: (1) extend coverage to the uninsured by using available Medicaid eligibility options; (2) provide a large array of optional services to eligible individuals; or (3) have established effective cost containment strategies in their Medicaid program.

#### New Home and Community-Based Care Program

NCSL supports The proposed home and community-based care program, a new state option, designed to provide home and community-based services to severely disabled individuals. While the funds are limited, this program option provides a wonderful opportunity for states to try innovative approaches to providing home and community-based services to severely disabled individuals. NCSL is particularly pleased with the level of state flexibility in the President's proposal. NCSL urges Congress to resist efforts to impose burdensome requirements on states and to retain the level of state flexibility provided for in the President's proposal.

#### MEDICAID LONG TERM CARE

WE SUPPORT THE OPTION TO INCREASE THE RESOURCE LIMIT AND TO INCREASE THE PERSONAL CARE ALLOWANCE TO \$70. THE PRESIDENT HAS COMMITTED TO COVERING THE ADDITIONAL COST TO STATES THAT WOULD OCCUR AS A RESULT OF RAISING THE PERSONAL CARE ALLOWANCE. WE ARE VERY SUPPORTIVE OF FEDERAL FUNDING FOR THIS MANDATE. NCSL OPPOSES THE NEW MANDATE REQUIRING STATES TO ESTABLISH A MEDICALLY NEEDY PROGRAM.

#### DISPROPORTIONATE CARE PAYMENTS

THE President proposes to repeal Medicaid disproportionate share hospital payments, but establishes a new \$800 million program that makes payments to hospitals that serve vulnerable populations. We hope this new program will adequately address the costs incurred by hospitals providing care to uninsured individuals under the President's reform program.

#### BOREN AMENDMENT

THE PRESIDENT WOULD REPEAL THE BOREN AMENDMENT AS IT APPLIES TO HOSPITALS, BUT THE AMENDMENT WOULD REMAIN IN EFFECT FOR OTHER PROVIDERS. NCSL BELIEVES THAT STATES SHOULD SET REIMBURSEMENT RATES UNDER MEDICAID.

#### QUALIFIED MEDICARE BENEFICIARIES (OMBS)

THE PRESIDENT'S PROPOSAL RETAINS THE REQUIREMENT THAT STATES CONTINUE TO PAY THE MEDICARE PREMIUMS, COPAYMENTS, DEDUCTIBLES, AND COINSURANCE FOR LOW INCOME MEDICARE BENEFICIARIES OR QUALIFIED MEDICARE BENEFICIARIES (QMBs). As a result of proposed Medicare changes, state costs associated with these individuals will rise. NCSL continues to oppose the mandatory state coverage of QMBs.

#### COVERAGE FOR UNDOCUMENTED INDIVIDUALS

NCSL SUPPORTS UNIVERSAL COVERAGE FOR ALL RESIDENTS OF THE UNITED STATES AND ITS TERRITORIES. AS STATES, WE HAVE NO ABILITY OR AUTHORITY TO CONTROL THE FLOW OF UNDOCUMENTED INDIVIDUALS AND MUST PROVIDE HEALTH CARE TO THESE PERSONS WHEN THEY APPEAR AT THE HOSPITAL OR CLINIC DOOR. WHILE SOME FUNDING WILL BE SET ASIDE

TO REIMBURSE HOSPITALS FOR CARE THEY PROVIDE TO UNINSURED INDIVIDUALS, AND EMERGENCY CARE THROUGH THE MEDICAID PROGRAM WILL CONTINUE TO BE AVAILABLE FOR QUALIFYING UNDOCUMENTED INDIVIDUALS, NCSL BELIEVES A MORE ADEQUATE AND SPECIFIC RESPONSE TO THIS PROBLEM IS ESSENTIAL.

# PREPARED STATEMENT OF KENNETH THORPE

# I. SUMMARY: Impact of the Health Security Act On States

The Health Security Act will reduce the cost of insurance in states through universal coverage, cost containment, and the elimination of cost shifting.

- Employers who currently offer insurance will save an average of \$605 per worker (1.6% of payroll, \$59.5 billion in total) on premiums in the year 2000.
- Workers who are in firms that currently offer health insurance will save an average of \$293 per worker (\$28.9 billion in total) on premiums in the year 2000.
- As a purchaser of health care coverage for their employees, states will save approximately \$5.6 billion in premium payments for active employees in the year 2000 due to slower growth in overall health care costs. Additionally, states will save an estimated \$704 million through federal support of health care for early retirees in the year 2000.

State expenditures for Medicaid and community-based long-term care are projected to decrease in the aggregate under the Health Security Act.

- Between 1996 and the year 2000, states will save an estimated \$51.4 billion in state Medicaid expenditures under the Health Security Act; an estimated \$40.3 billion represents coverage of Medicaid recipients through regional alliances, and approximately \$11.1 billion will be saved through the community-based long-term care program. In the year 2000, state Medicaid programs will save approximately \$24.4 billion -- \$2.9 billion results from the new home and community based long-term care program.
- When taking new state spending for the new community-based long-term care program into account, states will save, on net, nearly \$7 billion on community-based long-term care expenditures between 1996 and 2000 under the Health Security Act. In the year 2000 alone, states will save \$834 million on community-based long-term care.
- States will save \$47.3 billion between 1996 and 2000 under the Health Security Act, \$7 billion from the community-based long-term care program, and \$40.3 billion from the remaining changes in the Medicaid program. In the year 2000, this represents \$22.3 billion, \$21.5 billion in Medicaid savings excluding home and community-based care and \$834 million in savings from the home and community-based care program.

## IMPACT OF THE HEALTH SECURITY ACT ON STATES: YEAR 2000

EXPENDITURE CATEGORIES	W/O REFORM	REFORM	SAVINGS					
PURCHASING HEALTH COVERAGE UNDER THE HEALTH SECURITY ACT								
Employers' Share of the Premiums								
Total Employer Premium Payments: All Firms	\$303.5 billion	\$275.5 billion	\$28.0 billion					
Total Employer Premium Payments: Employers Currently Offering Insurance	\$303.5 billion	\$243.9 billion	\$59.5 billion					
Premium Payments as a Percent of Payroll: Employers Currently Offering Insurance	8.2%	6.6%	1.6%					
Premium Payments Per Worker: Employers Currently Offering Insurance	\$3,086 per worker (\$257 /month)	\$2,481 per worker (\$207/month)	\$605 per worker (\$50 /month)					
Families' and Individuals' Share of the Premiums								
Total Worker Premium Payments: All Firms	\$73.6 billion	\$53.7 billion	\$19.9 billion					
Total Worker Premium Payments: Workers in Firms Currently Offering Insurance	\$73.6 billion	\$44.7 billion	\$28.9 billion					
Worker Premiums: Workers in Firms Currently Offering Insurance	\$748 per worker (\$62 /month)	\$455 per worker (\$38 /month)	\$293 per worker (\$24 /month)					
New Federal Funds for Discounts*		S81.0 billion						
State Expenditures on Active State Employees	\$15.8 billion	\$10 2 billion	\$5.6 billion					
State Expenditures on Early State Retirees	\$1.3 billion	\$0.6 billion	\$0.7 billion					
MEDICAID								
State Medicaid Expenditures	\$123.2 billion	\$98 8 billion	\$24.4 billion					
State Medicaid Expenditures Net of Community- Based Long-Term Care	\$123.2 billion	\$101.8 billion	\$21.5 billion					
New Long-Term	CARE PROGRAM							
State Community Long-Term Care Expenditures	\$9.0 billion	\$8.2 billion	\$834 million					

<sup>\*</sup> Total discounts minus states maintenance of effort NOTE. Numbers may not sum to totals due to rounding

## II. HEALTH SECURITY ACT: Major Policy Changes Affecting States

The following is a brief description of some of the major policy changes under the Health Security Act that affect state expenditures.\*

## UNIVERSAL COVERAGE & COST CONTAINMENT UNDER THE HEALTH SECURITY ACT

The Health Security Act guarantees all American citizens and legal residents private insurance coverage for a comprehensive package of benefits. Coverage continues with no lifetime limits regardless of a change of employer, employment status, marital status or medical condition.

The Health Security Act relies on the requirement of shared responsibility for the purchase of health coverage. It strengthens the private, employment-based system and augments it with a commitment to make the purchase of coverage affordable through discounts to small business and families.

The Health Security Act carries out the commitment to control the rising costs of health care by:

- (1) Consolidating the purchasing power of consumers so that private payers in a competitive market can slow the growth of health insurance premiums. This process is backed up by a cap on the growth of insurance premiums.
- (2) Reducing the rate of growth of the Medicare and Medicaid programs without reducing benefits or quality of care.

### PREMIUMS UNDER THE HEALTH SECURITY ACT

Under the Health Security Act, health coverage is purchased in two shares: the individual or family share and the employer share. Each individual or family purchases a health plan designed to cover one of four categories by family type:

- (1) A single adult policy;
- (2) A policy covering two adults;
- (3) A policy covering a single parent with children; and
- (4) A policy covering two parents with children.

"Note. This analysis includes the major ways that states will be affected by the Health Security Act; other sectors that will be affected, such as hospitals and local governments, are not described in this report.

## **Employers' Share of the Premiums**

Generally, employers pay 80 percent of the weighted average premium calculated on a per worker basis within a regional alliance for the appropriate family type policy <sup>1</sup> Additionally, an employer may choose to pay part or all of the family share of the premium.

Employers' premium payments within regional alliances are capped. At full implementation, employers purchasing coverage through regional alliances will pay no more than 7.9 percent of payroll for health coverage for their workers. Businesses with fewer than 75 workers receive discounts that cap their payments to a sliding scale (3.5% to 7.9% of payroll) based on size and average wage.

## Families' and Individuals' Share of the Premiums

The family or individual pays the difference between the employer share and the actual premium of the health plan in which they choose to enroll. Those who choose to enroll in a lower-cost plan will pay lower premiums than those who choose higher-cost plans.

For families and individuals, as well as employers, premium payments are capped. Families with an annual income of \$40,000 or less pay no more than 3.9 percent of their income toward their share of the premium. Those with incomes below 150 percent of poverty receive discounts toward their share of the premium.

## MEDICAID UNDER THE HEALTH SECURITY ACT

Under the Health Security Act, Medicaid recipients under the age of 65 enter the alliance system to obtain the guaranteed comprehensive benefit package.

People not on cash assistance who now receive Medicaid choose their health plan and may qualify for discounts based on income, like other eligible individuals and families. States contribute toward discounts for their residents by maintaining current Medicaid spending efforts for this population.

Individuals who qualify for Aid to Families with Dependent Children and Supplemental Security Income also choose their own health plans through regional alliances. The federal and state governments make premium payments for these individuals based on current state and federal Medicaid expenditures.

For low-income children under the age of 19, a new program is created to provide services currently offered under Medicaid but not included in the comprehensive benefits package, such as hearing aids and non-emergency transportation. States maintain current spending for children receiving cash assistance.

State expenditures on Medicaid will decrease under the Health Security Act for several reasons:

- Coverage of current cash eligible Medicaid recipients through regional
  alliances: Acute care spending for cash eligible Medicaid recipients
  decreases because of their inclusion in regional alliances, where costs will
  not grow as rapidly as under the current system. States pay a premium for
  these services that is based on 95 percent of current expenditures for this
  population. In addition to this reduction in expenditures, states no longer
  make disproportionate share payments for their cash-eligible populations.
- Coverage of current non-cash eligible Medicaid recipients through regional alliances and the new program for children's supplemental services: Expenditures for non-cash eligible Medicaid recipients, like those for cash eligibles, are reduced due to their inclusion in regional alliances. Although the states make maintenance of effort (MOE) payments based on current expenditures for acute care services and disproportionate share for this population, these payments will not grow as rapidly as under the current system. Additionally, the federal government assumes the costs of supplemental services for Medicaid eligible children. Because the MOE payments for cash eligible children's supplemental services will grow at a slower rate than do current expenditures for these services, states achieve savings.

## NEW LONG TERM CARE PROGRAM UNDER THE HEALTH SECURITY ACT

The Health Security Act creates a new home and community-based long-term care program for individuals with severe disabilities regardless of income or age. The program is financed by:

Federal Government: New federal funds are allotted to states based on a
formula that includes the number of persons with severe disabilities among
other factors. Additionally, current federal Medicaid expenditures for these
services for the severely disabled will be used to fund the new program to
the extent that current Medicaid eligibles are served in the program. The
federal share of public costs ranges from 78 to 95 percent when fully phased
in.

<sup>&</sup>lt;sup>1</sup> The weighted average premium is the average of the accepted bids for all health plans in the alliance, weighted to reflect enrollment of eligible individuals among the plans

- States: State spending for the new program will be matched by the federal
  government, although at a rate substantially higher than that of the current
  Medicaid program Part of the state funds will come from the transfer of
  Medicaid expenditures for community-based long-term care for the severely
  disabled At the most, states will pay between 5 and 22 percent of the public
  program costs.
- Individuals: Participants will contribute based on their income.

States have the flexibility to organize services to meet their populations' diverse needs; at a minimum, states must provide personal assistance to eligible individuals needing assistance with activities of daily living. States have the option to continue to provide community-based long-term care services under the state Medicaid program.

## PUBLIC HEALTH INITIATIVES UNDER THE HEALTH SECURITY ACT

The Public Health Initiatives under the Health Security Act will provide states and communities with new funds to create partnerships between government, alliances, health care providers, and communities that will:

- Enhance the capability of communities to protect the health of their populations and to address high-priority local health problems;
- Increase the number of minorities in health professions, support graduate nurse training initiatives, and expand training projects for primary care physicians and physician assistants;
- Assure access to essential health services for all Americans, particularly low-income, isolated, hard-to-reach populations; and
- Provide the knowledge and information systems necessary to prevent diseases and provide medical care more appropriately and efficiently.

Due to universal coverage under the Health Security Act, most personal health services provided the Public Health Service will be paid for by insurance.

## III. BACKGROUND: States and Health Reform

Over the past decade, state governments, residents, and employers have faced rapid increases in the already high health care costs.

- Between 1980 and 1991, spending in states for hospital care, physician services, and prescription drug purchases in retail outlets rose at an average annual rate of 10.5 percent. (1)
- In 1993, states spent more on health care than on tax-financed higher education. (2)
- Between 1988 and 1990, the average annual growth in Medicaid expenditures was 15.7 percent (3), and it is expected that state Medicaid spending will nearly triple between 1990 and 1995. (4)

United States - Health Care Environment	STATISTICS
Percentage of Population Covered by Medicaid (1991) (5)	10.6%
Medicaid Payments per Recipient (1992) (6)	\$2,937
Average Annual Growth in Medicaid Expenditures (1988-1990) (3)	15.7%
Infant Mortality Rate per 1000 Live Births (1991) (7)	8.9

States have taken several steps to control the rise in health care costs and to increase access to health care for its residents. (8,9)

- Almost all states have initiated or enacted measures to improve access and contain costs. (8)
  - Fourteen states have enacted or proposed legislation designed to provide universal coverage for all state residents. (8)
  - Twelve states have enacted or proposed legislation designed to contain costs through managed competition or purchasing pools. (8)
  - Forty-seven states have enacted or proposed small group insurance reform; eighteen states have enacted or proposed insurance reform for individuals. (8)
- Examples of state health reform initiatives include:
  - Expanding access to health care for targeted population groups, such as pregnant women or children, through public sector, private sector, or a mixture of both, interventions. This often includes expanding Medicaid eligibility for coverage and services beyond Medicaid's traditional income restrictions. (8)
  - Small group and individual market reforms including guaranteed issue and renewal, limits on pre-existing condition exclusions, rating restrictions and benefit mandates. (8)
  - Containing costs through the use of managed competition or purchasing pools, provider rate setting, insurer premium caps, and global budgets. (8)

Acting alone, states are hampered in their efforts to control the growth of health care costs. The Health Security Act will enable states to control the growth of health care expenditures and assure access to care for its residents.

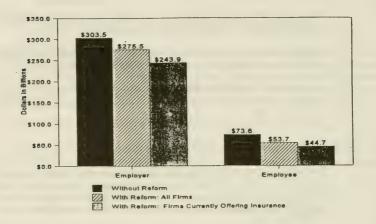
- Universal coverage, achieved through a federal/state partnership, will reduce the burden on state and municipal programs and providers that today help finance and deliver services to the uninsured and under-insured.
- Federal grants will help states provide special assistance to underserved rural and urban areas. States will be able to strengthen and improve essential public health efforts
- The Health Security Act will control the increase in health care costs by introducing greater competition into the health care delivery system.

## NOTES AND SOURCES

- Health Care Financing Administration, as published in Levit, et al., Health Affairs, Fall 1993
- National Association of State Legislatures, 1993
- Health Care Financing Administration, Office of the Actuary Per capita data from 1992. As cited in Office of (3) Management and Budget Health Reform Briefing Book October, 1993
- National Association of Budget Officers, 1993 (4)
- Congressional Research Service Medicaid Source Book, 1993 Update Prepared for the Committee on Energy and Commerce, U.S. House of Representatives. January 1993. P. 48. (5)
- Health Care rinancing Administration, as compiled by The Urban Institute, 1993. As cited in Office of Management and Budget Health Reform Briefing Book. October, 1993. (6)
- Centers for Disease Control & Prevention Monthly Vital Statistics Report, 42(2s) August 31, 1993 (7)
- BlueCross BlueShield Association State Legislative Health Care and Insurance Issues, 1993 Survey of Plans (8)
- Office of Management and Budget Health Policy Health Reform Briefing Book: States. October 1993 (9)

## IV. IMPACT ON THE PRIVATE SECTOR A. PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Total Annual Premium Payments: Year 2000



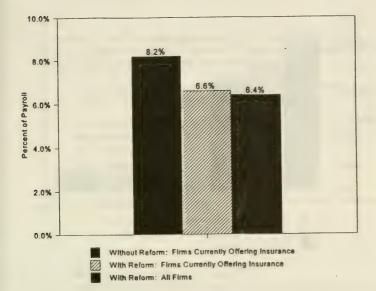
- Without reform, employers who currently offer insurance would pay an
  estimated total of \$303.5 billion in premiums in the year 2000. Under the
  Health Security Act, all firms, including those that do not currently offer
  insurance, will pay \$275.5 billion in premium payments for their employees.
  Firms that currently offer insurance to their employees will pay an estimated
  total of \$243.9 billion in premium payments -- \$59.5 billion less than they
  would pay without comprehensive reform.
- Workers who currently work in firms that offer insurance would pay an estimated total of \$73.6 billion in premium payments in the year 2000 without comprehensive reform. Under the Health Security Act, workers, including those who are not currently employed by firms offering insurance, will pay a total of \$53.7 billion in premiums in the year 2000. Employees in firms that currently offer insurance will pay an estimated total of \$44.7 billion in premiums in the year 2000, almost \$29 billion less than they would without comprehensive reform.

NOTE Numbers may not sum to totals due to rounding

SOURCE ASPE and the Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts

## EMPLOYER PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Premium Payments as a Percent of Payroll: Year 2000

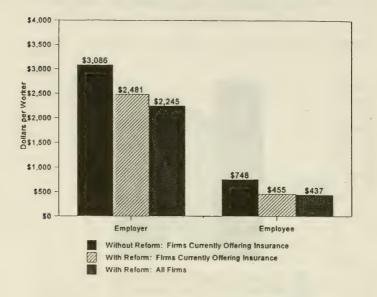


- The Health Security Act will reduce the amount that employers who currently
  offer health insurance will spend on premiums from 8.2 percent to 6.6
  percent of payroll, a reduction of approximately 20 percent due to reforms
  in the Act.
- In the year 2000, all employers will spend an average of 6.4 percent of their payroll on premiums under the Health Security Act.

NOTE Numbers may not sum to totals due to rounding

SOURCE ASPE and the Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts.

## PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT Average Annual Premium Payments per Worker: Year 2000



- For all employers, the average premium payment per worker will be an
  estimated \$2,245 in the year 2000 under the Health Security Act. Employers
  that currently offer health insurance will pay an estimated \$2,481 in premium
  payments for workers -- \$605 less than they would pay if there were no
  comprehensive reform.
- Under the Health Security Act, workers will pay an average premium share
  of approximately \$437 in the year 2000. Employees in firms that currently
  offer insurance will pay on average \$455. This is an estimated \$293 less
  than they would pay on premiums if there were no comprehensive reform.
  Savings will be even greater for those workers who currently purchase
  health insurance directly from insurance companies.

NOTE. Numbers may not sum to totals due to rounding.

SOURCE: ASPE and the Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts.

## B. DISCOUNTS UNDER THE HEALTH SECURITY ACT

### Year 2000

Qualified small and low-wage employers, low-income families, and early retirees will receive an estimated total of \$104 billion in the year 2000 for premium and out-of-pocket payment discounts under the Health Security Act.

- States' residents and businesses will receive an estimated \$81 billion in federal funds for discounts in the year 2000.
- The approximately \$23 billion remaining will come from state funds, a substitute for the \$27.8 billion that states would have paid for services for non-cash Medicaid recipients without reform.

NOTES: The gross and net discount estimates come from HCFA OACT Numbers may not sum to totals due to rounding

SOURCE: ASPE, HCFA OACT, and the Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts

## V. IMPACT ON THE PUBLIC SECTOR A. STATES AS EMPLOYERS UNDER THE HEALTH SECURITY ACT

### Year 2000

As purchasers of health care coverage for their employees, states will benefit from slower growth in overall health care costs.

Federal support of health care for early retirees will produce large savings for state employee health benefits programs. Under the Health Security Act, the federal government will cover the 80 percent employer share of the early state retirees' premiums. The state will assume the 20 percent family share.

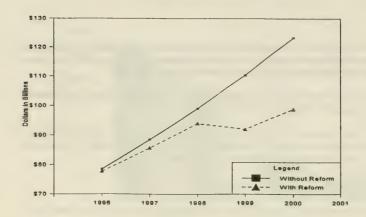
- States will spend an estimated \$10.2 billion on their active employee health benefits in the year 2000 under the Health Security Act. This represents an estimated savings of \$5.6 billion when compared to the estimated spending without reform of \$15.8 billion in the year 2000.
- States as employers will save an estimated \$704 million on its premium spending for retirees between the ages of 55 and 64 years in the year 2000.

NOTES Estimates are based on a survey of states as employers by the Segal Company (1993), employee workforce growth rates from WEFA, and reform premium estimates from The Urban Institute's TRIM2 model Coverage for refirees age 65 or older will not change under the Health Security Act. Numbers may not sum to totals due to rounding

SOURCE: ASPE

## B. STATE MEDICAID SPENDING UNDER THE HEALTH SECURITY ACT

Medicaid Growth: 1996 - 2000 \*



 Under the Health Security Act, states save approximately \$51.4 billion between the years 1996 and 2000. These savings will result primarily from the inclusion of Medicaid recipients in regional alliances, where health care costs will not grow as rapidly as in the current system.

### ASSUMPTIONS AND NOTES

Assumes that

States will continue their spending on non-cash adult wrap-around services,

Sources of revenue for Medicaid disproportionale share remain and funds were used for uncompensated care,

Long-term care includes both institutional and community-based long-term care. These estimates include offsets due to the new community-based long-term care program (see next section)

Maintenance of effort payments include expenditures for non-cash alliance covered services, non-cash disproportionate share, and cash children's wrap-around services.

Numbers may not sum to totals due to rounding

SOURCE: HCFA OACT, OLP and ASPE

## STATE MEDICAID SPENDING UNDER THE HEALTH SECURITY ACT Medicaid Expenditures: 1996 - 2000

	Dollars in Billions							
	1996	1997	1998	1999	2000	Total		
(alternative Manifeston)	613	TS (	Ŋees:	re v	60.0	4110%		
Halify Skolfungs	ार	156	, iško	910	99.70	41.77		
Acute Care Medicaid	49 1	51 1	43 8	38 1	41.1	223 2		
Long-Term Care Medicaid	26 1	27 1	29 5	32.1	35.0	149.8		
Maintenance of Effort	2.5	7.4	20 6	21.7	22.6	74 9		
NET STATE MEDICAID SPENDING	-0.8	-28	-5 0	-18.3	-24.4	-51 4		
NET STATE MEDICAID LESS COMMUNITY-BASED LONG-TERM CARE SAVINGS	0 5	-0 8	-2 7	-15.7	-21.5	-40.3		

<sup>\*</sup>Estimated savings will change slightly due to normal baseline revisions which accompany new economic data.

- Overall, states will save an estimated \$51.4 billion on Medicaid expenditures between 1996 and 2000 under the Health Security Act; \$40.3 billion represents savings from coverage of Medicaid recipients through the regional alliances and other policy changes under the Health Security Act. Approximately \$11.1 billion will be saved through the new community-based long-term care program
- Medicaid spending on acute care, which includes premium payments for cash assistance recipients and wrap-around services for adults, will be an estimated \$41.1 billion in the year 2000. This will be lower than the acute care spending under the current system because of slower growth of health care costs under the Health Security Act.
- Medicaid spending on long-term care under the Health Security Act will be approximately \$35.0 billion in the year 2000. This includes coverage of institutional long-term care and community-based long-term care for the non-severely disabled population.
- States will contribute an estimated \$22.6 billion in the year 2000 in maintenance of effort payments that will be used for premium discounts for their low-income residents and small businesses

### ASSUMPTIONS AND NOTES

Assumes that

States will continue their spending on non-cash adult wrap-around services,

Sources of revenue for Medicaid disproportionale share remain and funds were used for uncompensated care,

Long-term care includes both institutional and community-based long-term care. These estimates include offsets due to the new community based long-term care program (see next section).

Maintenance of effort payments include expenditures for non-cash alliance covered services, non-cash disproportionate share, and cash children's wrap-around services.

Numbers may not sum to totals due to rounding

SOURCE HCFA OACT, ASPE, and OLP

## C. NEW LONG-TERM CARE PROGRAM UNDER THE HEALTH SECURITY ACT

State Expenditures for Community-Based Long-Term Care: 1996 - 2000

	Dollars in Billions						
	1996	1997	1998	1999	2000	Total	
aranisis pu	3.0		11.	// V/5	466	37/13/7	
State Medicaid Spending (1)	3,808	5,556	5,968	6,413	6,894	28,640	
State Only Spending on the Severely Disabled (2)	1,311	1,853	1,974	2,070	2,149	9,357	
HEAL FREE SHIPLING	i AriXI a	-36D-4	ુ રાગેલ્ટ્રિયા જ	( ( A )	(Val)		
New Program Spending (3) State Spending to Match New Federal Funds	275	1,511	2,130	2,829	3,575	10,923	
State Spending to Match Medicaid Transfer	877	438	526	608	681	2,527	
State Spending on Continuing Medicaid	2,552	3,611	3,672	3,794	3,953	17,582	
NET STATE SPENDING ON COMMUNITY-BASED LONG-TERM CARE	-1,415	-1,849	-1,614	-1,252	-834	-6,965	

- States will save an estimated \$834 million on their spending for community-based long-term care under the Health Security Act in the year 2000, with a total savings of approximately \$7 billion between 1996 and 2000.
- States would spend an estimated \$9 billion in Medicaid and non-Medicaid (state-only) funds on home health, personal health care services, and home and community based waivers in the year 2000 in the absence of comprehensive reform

<sup>\*</sup> Estimated savings will change slightly due to normal baseline revisions which accompany new economic data

- Under the Health Security Act, expenditures for community-based long-term care will be divided between the new program and the Medicaid program. States will spend an estimated \$3 6 billion in the year 2000 to match the federal funds for the new program. Additionally, states will spend approximately \$681 million to match their share of the Medicaid expenditures in the year 2000
- States will spend an estimated \$4 billion in the year 2000 for community-based services that continue to be offered through Medicaid.
- Coupled with savings from changes in the Medicaid program (\$40.3 billion), states will save an estimated \$47.3 billion between 1996 and 2000.

NOTES

- (1) Projected Medicaid spending for home health, home and community-based waivers, personal care, frail
- (2) Includes only estimated spending for persons who are likely to meet the eligibility criteria for the new program
  (3) Assumes full state participation in the new program
  Program is not fully implemented until FY 2003

These net savings include some of the Medicaid program savings counted on the previous page \* Estimated savings will change slightly due to normal baseline revisions which accompany new economic data

SOURCE ASPE

## Federal Expenditures for Community-Based Long-Term Care 1996 - 2000

	Dollars in Billions					
. Manual Carlo Control State Control C	1996	1997	1998	1999	2000	Total
OURRENT SYSTEM (I)	4875	G(1976)	- Terr	10 7 1 5 E	66.6	
New Program Spending	**,4.0); (	4:36°.	Alberta.	100.4	राज्य .	غ <u>ای</u> زا
New Federal Funds for Program Estimated Medicaid Transfer (2) Federal Spending on Continuing Medicaid (3)	4,546 1,425 3.033	7,775 2,251 4,300	11,009 2,717 4,390	14,661 3,151	18,676 3,555	56,663 13,099
NET FEDERAL SPENDING ON COMMUNITY-BASED LONG-TERM CARE	4,282	7,436	10,716	14,423	18,463	21,066

- The federal government would spend an estimated \$8.5 billion in Medicaid funds on home health, personal health care services, and home and community based waivers in states between in 2000 in the absence of comprehensive reform.
- Under the Health Security Act, states will receive an estimated \$18.7 billion in new funds in the year 2000 for the new program for the severely disabled. Additionally, states will receive an estimated \$3.6 billion in Medicaid funds to match the transfer of state Medicaid funds to the new program.
- States will receive an estimated \$4.8 billion in the year 2000 in federal Medicaid expenditures for community-based services that continue to be offered through Medicaid.
  - Between 1996 and 2000, federal spending for home and community-based health care services will increase by an estimated \$55.3 billion under the Health Security Act.

NOTES

(1) Projected Medicaid spending for home health, home and community-based waivers, personal care, frail

(2) Federal Medicaid spending on persons with severe disabilities who are expected to be transferred to the new program. Assumes that no more than 75% of the new program's expenditures will be used for the Medicaid severely disabled during the phase-in

(3) Medicald with federal matching funds continues for the non-severely disabled receiving home and community-based long-term care

Program is not fully implemented until FY 2003

Estimated savings will change slightly due to normal baseline revisions which accompany new economic data

## D. PUBLIC HEALTH INITIATIVES UNDER THE HEALTH SECURITY ACT

## Public Health Service Funding for States: 1997 - 2000 (Dollars in Millions)

	1997	1998	1999	2000	TOTAL
NEW PHS FUNDS	B 630	4.005	8)955	3 555 + 5	15745 A
Health Services & Workforce Funding (1)	2,630	2,905	2,855	2,455	10,845
Health Research Funding (2)	1,000	1,100	1,100	1,100	4,300
ÖFFSETS .	1,582	2,510	2,729	2,729	9,550
TOTAL NET FUNDS	2,048	1,495	1,226	826	5,595

- Between 1997 and 2000, Public Health Initiatives of the Health Security Act will
  provide the states and its localities with an estimated \$5.6 billion in new funds
  for its community health centers, training of primary care physicians, core public
  health functions such as immunizations and disease prevention, and health
  research, among other programs
- With universal coverage, payments from health plans will replace (offset) the current federal Public Health funds for the personal health services, totalling approximately \$9.6 billion between 1997 and 2000

### NOTES

It is assumed that all states will implement reform in 1997

- Federal funds for Health-Related Services and Workforce are allocated to states based on the state's percentage of its
  population beneath the poverty level in 1992
- (2) Federal funds for Health Research are allocated to states using proportional distribution based on total FY 1993 AHCPR and NIH funds to each state
- (3) Offsets are allocated to states based on FY 1993 distribution of funds from HRSA, SAMHSA, CDC, IHS, and NIH

Numbers may not sum to totals due to rounding

SOURCE OASH, PHS

## PREPARED STATEMENT OF STEVEN WETZELL

Mr. Chabman and members of the committee, I am Stove Wetzell, executive director of the Business Health Care Action Group. On behalf of our 21 member employers, I would like to express our sincere appreciation for the opportunity to testify today on the role states and the federal government in health care reform.

## Who We Are

Prior to addressing state versus federal jurisdiction over the activities of self-insured, multi-state health care purchasers, it may be helpful to provide some background information about the Business Health Care Action Group (BHCAG) and how it benefits the regional and national health care market. The BHCAG strongly believes that the private sector can and should play a significant role in solving our nation's health care problems. We believe we have developed a model for private sector based reform that can improve the quality of care and control costs without cost shifting to other health care purchasers or imposing the unnecessary burden of state regulation.

BHCAG membership currently includes twenty one, large self-insured employers. Our member companies include:

Bemis Company, Inc.

Cargill, Inc.

Carlson Companies

Canax

Medtronic, Inc.

Minnegasco

Minnesota Mutual

Norwest Corporation

Ceridian Corporation Northern States Power Company
Dayton Hudson Corporation The Pillsbury Company
First Bank System Rosemount Inc.

General Mills, Inc.
Honeywell Inc.
TENNANT
IDS Financial Services, Inc.
3M

Land O' Lakes

This coalition has developed a self-insured health plan which member companies offer to more than 250,000 people in Minnesots, western Wisconsin, eastern North and South Dakota, and northern Iowa. The employers and their employees spend about \$500 million annually on health care services within the region. Collectively, the member employers of the BHCAG provide health care coverage for more than 1.5 million Americans residing in all 50 states and the District of Columbia at an annual expense of about \$1.5 billion.

We have agreed to a common comprehensive banafit plan, contracted with the same network of health care providers, and negotiated a long term contract with regional health care providers which contains aggressive quality and cost guarantees.

Our primary goal is to provide our employees, retirees and their families with high quality, affordable health care by creating provider accountability for quality health outcomes and defining the case that is necessary to treat patients in the most cost effective manner. We also are using this model to develop similar competing health plans in the region and across the country. We believe we have demonstrated our ability to meet these objectives without cost shifting to other purchasers or requiring the burden of state regulatory requirements.

We believe that employers who purchase health care can use their influence as a catalyst for market based progressive reforms, not only for those to whom we provide coverage, but also for the community as a whole. This approach to delivery system reform will benefit consumers, purchasers, and providers who deliver high quality, cost effective care. We believe that the experience gained through this initiative can be applied to health care reform on a broader basis.

## What We Have Accomplished

Participating BHCAG companies began introducing a new health care plan designed around these principles effective January 1, 1993. Our results in 1993 have been impressive:

- Although most BHCAG member employers offer several other health plans to their employees and retirees, including HMOs, PPOs and traditional fee-for-service indemnity plans, more than 90,000 of 250,000 eligible employees, retirees and their dependents have voluntarily enrolled in the coalition's health plan entering 1994.
- The coalition has grown from 14 to 21 employers with no money spent on "marketing" the coalition to other employers in the community.

- The plan offers comprehensive benefits. The plan generally provides 100% coverage
  after reasonable copayments are made by plan participants when contracted providers
  are used. In addition to comprehensive coverage for catastrophic health care needs,
  the plan covers preventive care, mental health, substance abuse and prescription drugs.
- The plan protects the members right to choose their own physician while offering financial incentives to use the most cost effective, high quality providers.
- The cost to cover each employee in 1993 was only \$2,500. With each employee
  having an average family size of 2.1 lives, the average cost for each covered member
  of the plan was \$1,200.
- Overall costs were reduced 11% in 1994 compared to similar HMO products currently available. Cost reductions were largely due to reduced utilization and improved efficiency, not due to provider 'discounts' which would result in cost shifting to other purchasers.
- Administrative costs were 8% 10% of total plan costs, including the costs to conduct
  coalition activities, and will not increase in 1994. The coalition's budget was less than
  1% of total health care expenditures for the health plan.
- The annual rate of increase in plan cost is 4% 5%, significantly below recently passed state targets on health care cost increases which apply to state regulated purchasers.
- Contracted providers have developed and agreed to follow common practice standards to assure consistent, high quality care for plan participants.
- Contracted providers have agreed to and are providing data to measure patient outcomes to document and improve the quality of care.
- Contracted providers and purchasers are jointly assessing new medical technologies to
  assure that resources are allocated to procedures and medical devices with a proven
  benefit to petients.
- Contracted providers have developed a prototype for an automated medical record to facilitate the collection of data to measure patient outcomes and more efficiently gather information to support quality improvement and cost containment.
- Contracted providers and BHCAG member employers are developing health education
  classes which will be offered at the worksite of coalition members.
- An annual member satisfaction survey will be conducted to solicit consumer foodback and maintain accountability for the overall value of the health plan to its participants.
- Efforts are underway to create an insured product for small employers to allow businesses of all sizes to participate in and benefit from coalition activities.
- Additional competing coalition sponsored plans will be developed and compete with the initial plan beginning in 1996.
- Two other coalitions have adapted our model to stimulate similar market changes in Dayton, Ohio and Rockford, Illinois. Employers in San Francisco, St. Louis, Des Moines, Baton Rouge, Grand Forks, Michigan and Phoenix have requested information on our activities and considering similar private sector initiatives modeled after our project.

 Health care providers from New York, Oregon, Arizona, California, Washington, Illinoia, Michigan, Ohio, Kansaa, Wisconsin, and Texas have requested information regarding our purchasing initiative to begin preparing for similar private sector purchaser expectations in those states.

## The Minnesota Health Care Market

"Managed Care" is not a new concept in the Twin Cities of Minneapolis and St. Paul. Driven by the demands of private purchasers, organized systems of care have been evolving for many years.

At the time the BHCAG decided to engage in a group purchasing initiative, the market was dominated by state regulated Health Maintenance Organizations (HMOs) and Preferred Providar Organizations (PPOs). It is estimated that about 70% of the residents of the greater Minneapolis/St. Paul urban area are currently enrolled in various forms of 'managed care' health plans featuring contracted relationships between providers and insurance carriers or health maintenance organizations. In addition, the market has significant numbers of large group medical practices and multi-specialty clinics. Health care costs in the Twin Cities are about 18% below the national average largely due to the impact of managed care products and organized systems of care in the market place which have been created in response to private sector purchaser demands.

In spite of this high penetration of managed care products, the member employers of the BHCAG observed that there was need for improvement in the quality and efficiency of the health care system. Meaningful quality data about competing health plans and provider networks was not available to consumers or purchasers. Because providers were contracted with multiple managed care and insurance vendors, there was no real incentive at the individual hospital or clinic level to compete for patients based on quality and cost.

In addition, managed care contracts with providers were largely based on discount fee for service arrangements. While addressing unit pricing, this approach did not get at the issue of quality or ineffective and unnecessary care. In addition, like Medicare/Medicaid reimbursement policies over the past several years, the extensive use of discounts in managed care products to generate "savings" resulted in significant cost shifting by health care providers within the Twin Cities market to participants in non-managed care (i.e. - indemnity) health plans. Medical inflation rates, while running well below the national average, still exceeded real growth in the economy.

In this environment, BHCAG decided that purchasers, working directly with preferred providers in a long term arrangement, could improve on the current health care delivery system.

Recently, the Minnesota legislature has passed a series of laws which will apply to the Minnesota health care market. Although the theory upon which the Minnesota legislation was based would support a competitive, relatively unregulated market place, the state legislature and the administration appear to woving more and more towards a highly regulatory approach with numerous rules which would limit the creativity and innovation of the private sector if it fell under the new rules.

The creative activities of the BHCAG which are demonstrably improving the quality and cost effectiveness of regional health care providers could be significantly and adversely affected if our self-insured, multi-state employers became subject to state regulatory requirements. Such as move is currently being considered in Minnesota, as regulators seek to do what they do - regulate.

Under legislation already passed and currently being considered, prices would be driven by states expenditure targets rather than by an efficient, competitive, unregulated market. Provider contracting would be subject to state rules dictated by the influence of special interests. Mandated benefits would be determined by the impact of lobbying by special interests, not based on where the best investment of our health care dollar lies. The state would be responsible for developing the standards by which care is delivered, and providers would be expected to follow state practice guidelines. Mandatory data submission would be targeted toward measuring expenditures, not focused on collecting data to improve the quality of health care.

Federal versus State Regulation of Multi-State, Self-Insured Employers and It's Potential Impact on Private Sector Health Care Reform Efforts

The prevailing concern among self-insured, multi-state employers is that they will be forced to deal with as many as 51 different approaches to regulating their health care purchasing activities if excessive rights are granted to states and the District of Columbia. Although we acknowledge that certain reforms are needed, regulations pertaining to multi-state, self-insured employers should be established at the federal level. To allow multi-state, self-insured employers to offer high quality, cost effective health plans to our employees, retirees and their families, it is extremely important that we not be subjected to state regulation.

The solf-insured member employers of the Business Health Care Action Group have demonstrated an ability to offer comprehensive, high quality health care coverage at low cost without cost shifting or the unnecessary burden of state regulation. We should avoid an environment which allows state-by-state regulation of health care purchasing which would only inhibit and discourage this and other evolving private sector based initiatives which are significantly contributing to our national goal of provide affordable, accessible health care for all Americans.

Subjecting multi-state employers to the excessive regulatory burden imposed by 50 states would ultimately undermine efforts in the private sector which are currently working towards reforming the health care system at no direct expense to the tarpsyers. Instead of focusing private sector resources on psying for health care for employees, retirees and their families, we would be forced to warte limited resources complying with a maze of different and conflicting state regulations, many of which would destroy current employer incentives to contain health care costs and improve health care quality.

Health care purchasing does not follow state borders. Individuals employed in one state may pursue health care in another state. The BHCAG coalition health plan currently covers employees, retirees and their families in five states. State-by-state regulation would inhibit efforts of multi-state employers to create the most cost effective health plans for their employees, retirees and their families.

Certain issues pertaining to the regulation of self-insured employers would be very appropriately addressed at the federal level. We believe that underwriting reform should be a first priority for both insured and self-insured health plans. Although employers should maintain some degree of flexibility to determine benefit eligibility rules, those that do offer health plans should be prohibited from imposing precessing condition exclusions for new hires. However, this should only be applied to self-funded plans on the same basis as applied to insured health plans. Further, employers should maintain their current flexibility to impose preexisting conditions exclusions and waiting periods for those employees and retirees who are offered coverage and elect to delay enrollment until they have a defined health care need.

We believe that competing health plans must be held accountable for quality and cost based on national standards which benchmark their performance. Any data required from multi-state health care purchasers to meet state or federal needs should be gathered at the federal level and available to states through a national "clearing house." This approach gives states access to data on self-funded plans without subjecting multi-state employers to numerous, inconsistent and conflicting data requests.

Based on experience, we are seriously concerned about the content of any mandated benefit set which might be imposed on self-funded plans. However, we strongly favor federal standards over state standards if there is to be a mandated benefit design for those who choose to offer their employees and retirees employer sponsored health plans.

All of society should contribute to an appropriately defined tax base based on ability to pay to provide subsidies to those who could not otherwise afford health care coverage. Our member employers are willing to pay their fair share to help subsidize low income Americans, even though they voluntarily pay the majority of the cost of health care for more than 1.5 million Americans. If business is to contribute to helping those who could not otherwise afford health care coverage, the tax base should be based on ability to pay and not on the size of an organization's payroll, whether or not they offer health benefits, or insure or self-insure the risk of offering those benefits.

This is a major problem in Minnesota, where the legislature has elected to generate revenue to subsidize premiums for low income families partly based on the premiums paid by employers who offer insured health plans. This creates an unfair tax base which favors large, self-funded plans. Federal standards should be adopted to prevent this type of state driven legislation which does not treat businesses of all sizes on a fair and equitable basis. Granting states rights to regulate self-insured employers is not the answer to this problem. The answer lies with appropriately defined federal rules which create a tax base to provide revenue to fund premiums for low income Americans that treats all businesses equitably based on ability to pay.

Although we do not believe that state or federal regulation of self-funded efforts to negotiate commets with providers is needed, any regulation with is deemed necessary should be at the federal level. In Minnesota, we find the political process subject to significant pressure from special interests, who, out of fear relative to their ability to succeed in a competitive market, are actively lobbying the state legislature to force state regulated purchasers to contract with them. Under our current federal protection, self-funded plans are free to contract with providers based on their quality and cost of care, not based on state mandates created under pressure from special interests.

ERISA is the current federal statute which protects us from these state regulations. However, it also inhibits our ability to create appropriate financial incentives for our providers to reward them based on the quality and cost effectiveness of their care. Under our interpretation of ERISA, we cannot impose risk on providers for services they do not directly own without falling under state insurance regulation. We strongly encourage the federal government to set clear standards allowing multi-state, self-insured employers to negotiate any form of risk sharing arrangement with providers without triggering excessive, expensive and inappropriate state regulation of their health care purchasing activities.

Federal statutes currently regulate solvency requirements for self-funded health plans.

This is the appropriate jurisdiction for regulation and should be maintained at the federal level

Public policy must also be developed to address the issue of funding and dissemination of new and evolving medical technologies. The federal government should be responsible for

establishing national standards related to this issue which apply to all health plans, whether they are insured or self-insured. An equitable tax base should be defined by the federal government to fund the development of new technologies and medical education.

Finally, we believe that local private sector purchasing alliances should be allowed to form under general federal regulation. Although small businesses would like to participate in the BHCAG's group purchasing project, we may not be able to meet their needs due to the excessive regulatory burden imposed on these insured health care purchasers who are subject to state regulation. We suggest the federal government consider guidelines to establish appropriate public accountability for private sector purchasing alliances and that these organizations be exempt from direct state regulation.

## Other General Concerns

The member companies of the BHCAG would also like to take this opportunity to share several other concerns pertaining to addressing our national health care issues. Senator Durenberger and representatives of our state have frequently pointed out that both the state of Minnesota, its citizens and private health care purchasers are currently being treated inequitably by federal policy pertaining to Medicare and Medicaid funding. We share their concerns.

Approximately 600,000 elderly and disabled Minnesotans are enrolled in Medicare. Those enrollees and their employers pay a premium to the federal government. The federal government then sets rates for health care services that vary by geographic area. The method used by the federal government to pay Health Maintenance Organizations for services to Medicare enrollees results in payments to Minnesota HMOs that can be more than \$200 less per person per month than in other parts of the country. Minnesota HMOs then make up the difference by charging higher premiums, by not offering additional benefits such as prescription drug coverage, and by cost shifting to other health care purchasers in the state.

The Federal Health Care Financing Administration's announced rates for Minnesota in 1994 actually went down due to the increased efficiency of our health care system. In addition, over 400,000 Minnesotans are covered by the state/federal Medicaid program. Rates paid in that program also affect the cost of health care for other purchasers. This unfair federal treatment for Minnesota businesses, taxpayers, and Medicare/Medicaid participants must be addressed in any comprehensive federal health care reform.

Finally we must express our strong opposition to the anti-competitive impact on large, multi-state employers by the Administration's proposed legislation. It must be made clear that the plan leaves no opportunity or incentive for creative, private sector based initiatives similar to that of the BHCAG. Employers would prefer to pay the proposed federal payroll tax rather than bear all the administrative complexities and significant financial risk of operating a corporate alliance as proposed in the Administration's plan.

Simply reducing the size of employers who may form a corporate alliance will not solve the basic problems in the proposal. Employers must have flexibility to make health care purchasing decisions on a market-by-market basis. Further, employers who elect to operate or belong to a corporate alliance must not be penalized if costs exceed some arbitrarily determined federal limit. Corporate tax subsidies to fund coverage for low income Americans should not be determined by whether or not an employer belongs to a alliance, offers health plans, or the size of its payroll. A more rational tax structure should be defined based on a system which treats businesses of all sizes consistently and equitably.

Employer mandates are themselves a problem. They will cost the nation valuable jobs. Employer mandates which require business to pick up 80% of the cost of coverage without any control over how costs are contained are cause for serious concern and create a dangerous situation where those who fund a federal anthiement program have no control over the quality or cost of health care.

We must design a federal framework which provides limited and appropriate regulation of multi-state, self-funded health plans, yet maintains current employer incentives to contain health care costs while improving the quality of care. Because the Administration's proposal eliminates incentives employers to actively work to improve the quality and contain the cost of health care, our member companies would probably abandon our innovative project to reform health care reform as well as other private sector initiatives to contain costs and improve quality.

Thank you allowing us the opportunity to share our concerns and opinions. As an active model of progressive, private sector based market reform, the Business Health Care Action Group and its member employers would welcome the opportunity to continue to share our experience as we address the serious issue of national health care reform.

## PREPARED STATEMENT OF RICHARD E. CURTIS

Mr. Chairman and members of the committee, I am Richard E. Curtis, President of the Institute for Health Policy Solutions, a not-for-profit, non-partisan organization that does not advocate specific legislation. I am here today as an individual with substantial experience in analyzing and developing policy both with respect to federal and state roles in health care financing, as well as health insurance market reform.

My initial comments will focus on the question of who might perform which health insurance regulatory roles in the context of health system reform. I agree with the judgment reflected in the President's plan and most other system reform proposals before the Congress: there should be federal standards in the areas of access to coverage, rating, renewal, continuity, and basic benefits. Only through federal action can all Americans be guaranteed access to medical care coverage for a basic level of services. Moreover, as individuals move from state to state they should be assured of continued access to health services and financial protection. There are other reasons for establishing federal standards. It is probably unrealistic to expect changes in federal law to prohibit self-insurance by large employers or to give states blanket authority to regulate health insurance plans offered by large multi-state employers. Federal rules are necessary to apply issuance, continuity and basic benefit requirements to employers permitted to self-insure, and to assure that employees and their families have the same continuity of coverage protections whether their job change takes them from a small to a large firm or from a self-insured to an insured plan.

Federal rating standards are also sensible under comprehensive health care reform that involves substantial federal subsidies to purchase coverage. The federal government has a strong interest in assuring that these subsidies are used in a cost effective and fair manner across states. The rules for setting premiums could have a dramatic impact on the size and incidence of subsidies. (The alternative would be for subsidies to be insensitive to the actual cost of coverage for a given person or firm.) It would also be extremely difficult for the federal government to achieve universal coverage through mandated premium contributions without getting into the details of what rating rules the financial obligations would be on a national basis. Similarly, it is unrealistic to expect the federal government to mandate the purchase of coverage without defining at least basic specifications regarding the benefits provided under this coverage.

On the other hand, I believe the federal government should avoid being overly prescriptive about issues such as defining geographic rating areas and certifying qualified health plans and their service areas. Health care is a local service. Integrated health plans–HMOs, PHOs, and the like–are normally organized on a local basis with locally defined service areas from which they draw enrollees. The assessment of the adequacy of health facilities and resources is appropriately done on a local and regional basis. Referral patterns from primary care physicians to specialists and to hospitals often occur within relatively small geographic areas. (Referrals for highly sophisticated tertiary services are often appropriately made to regional or national centers of excellence.) In general, the boundaries of local and regional health care systems are determined by factors unique to each area and cannot be precisely defined on the basis of any abstract

principles that can be captured in federal legislation or regulations. Because the nature of these relationships will vary widely from area to area, those who draw boundaries need to be able to assess the local situation. This logic suggests that states and localities should have primary responsibility for determining defining geographic boundaries for alliances' rating and other purposes.

The regulatory process also involves monitoring and enforcing what rules or standards are established. In general, this responsibility should fall to the states, as much of it does today. There are a number of reasons for this. First, as noted above, there is a range of related health care financing and delivery factors that are endemically local in nature. States are more apt to be sensitive to such local needs and activity than the federal government. In addition, most states already have in place at least a partial infrastructure to regulate the kinds of activities we have discussed. Conversely, federal agencies have very little experience in regulating private health insurance. And while states have often been criticized for having widely varying and sometimes poor regulatory capacity, much of this is the product of a system which evolved in the absence of any clear guidelines for regulatory goals and responsibility. In general, we believe that under the appropriate federal framework there is greater potential for effective implementation, monitoring and enforcement of regulation at the state level.

These market rules are needed under federal health systems reforms to protect consumers, to curtail the abuses often found in the current market, and to allow individual carriers to behave responsibly without jeopardizing their financial survival. However, such rules alone are unlikely to fix critical inefficiencies and inequities endemic to a marketplace where each small employer group and self-employed individual separately contracts with a health carrier. This market consists of myriad health plans offering a mind-numbing array of benefit plans to groups too small to bear risks or to devote sufficient resources to act as prudent purchasers. In such a highly fragmented market, there are many opportunities for selective marketing and servicing to attract and retain only lower risk persons. Many of these opportunities would remain even if standardized benefits and community rating were required. A carrier could approach only smaller employers it found to be attractive, and could be illusive (e.g., locate in an inaccessible area and only have an unlisted number) if a higher risk customer attempted to reach it. It would be virtually impossible to regulate the broad range of tactics that might be used to selectively market.

The administrative costs in small employer and individual health insurance are typically very high. They average between 25 and 40 percent of premiums for very small employers and individuals. And there is high turnover of both small firms and their workers, making place of employment a particularly unstable source for this coverage. Even in firms with between twenty-five and ninety-nine employees, the average job tenure is only half that of larger firms. And job turnover is higher still for the currently uninsured, small-firm workers that will hopefully be able to obtain coverage through health care reforms.

To the extent that these populations are enrolled in integrated health plans which have limited provider panels, their high rate of job mobility creates yet another problem with employment-based health care coverage. As they frequently change employers and, therefore, health plans, they would typically have to change physicians.

Compounding the high administrative costs and employee turnover found among small firms is the low per worker payroll level, which for establishments under size twenty is approximately half that of establishments with one thousand or more workers. The subsidies needed to achieve coverage for these populations will disproportionately go toward coverage of small-firm workers. Because small firm employees have relatively low average family income, this will be true regardless of whether an employer or an individual mandate is used to achieve universal coverage. It would seem clearly inadvisable for government to invest billions of subsidy dollars in such an unstable and administratively inefficient market. And for very small employer markets, it is simply fallacious to argue that expanding employer-based coverage is building an existing system that works for the majority of workers and their families. Only one in four workers in firms under size ten currently receives coverage through their employer.

To achieve an efficient structure and prevent risk selection by health plans, we believe that individual and small employer-based contracting and coverage should be replaced by pooling mechanisms such as the alliances or HIPCs included in several federal reform bills. Some have suggested that such organizations be required only for low-income firms and employees that receive federal subsidies. This would avoid public spending on the high administrative costs found in the small employer and individual markets. While avoiding such constraints, however, such policy mechanisms are likely to be viewed as entities established for low-income

populations and become stigmatized as "welfare" organizations, resulting in income tiering as middle and upper income populations avoid participation. To avoid this, alliances (HIPCs) should be the mandatory vehicle for coverage for all individuals and small-firm employees.

This policy also has the advantage of allowing individuals to retain their choice of health plans (and their physician in the case of integrated health systems) as they change job status and employer. Savings would also accrue due to reductions in the administrative cost now associated with the high rates of health plan enrollment turnover (typically 30 percent) for the small employer market.

For larger employer-sponsored health plans, the states' authority to regulate insurance is over-shadowed by the option to self-insure. Self-insured employer plans escape state jurisdiction through the ERISA preemption of state regulation of employee benefit plans. For example, if a state were to impose community rating requirements on health insurance premiums across all size employers, low-risk larger employer groups would keep their own costs down by self-insuring, leaving mostly higher risk large groups in the community pool. The net result would be that smaller employer groups (with lower average wages) would realize a cost increase as they are asked to cross-subsidize large (higher wage) insured groups. While an employer must file with the Department of Labor in order to claim exemption as an ERISA plan, there are few rules (with the exception of COBRA) with respect to these plans. For example, there is no constraint on preexisting condition limits, no requirement to recognize previous employer coverage, and no floor on the scope of benefits. The irony is that the current federal tax expenditures disproportionately subsidize this form of coverage.<sup>5</sup>

To the extent that federal law continues to permit self-insurance options, there remains the question of who should regulate these entities. First, we believe that self insurance should not be an option for employers under a certain size (e.g., under 500). Only entities that can be reasonably expected to bear their own risk and have a large enough base over which to have a stable, broad risk pool can be relied on to protect their insureds. Further, the sheer number of medium-sized, self-insured employers makes the prospect of effectively monitoring behavior and enforcing such rules daunting. We estimate that approximately 20,000 to 30,000 firms and 50,000 to 60,000 establishments with between 100 and 999 employees currently offer self-insured health plans to their workers. If real protections are to be guaranteed for their employees, either there will need to be a huge expansion in the number of government regulators, or an approach must be found that drastically reduces the number of regulated entities.

There are at least three alternative policy solutions for medium size firms: 1) Firms between size one hundred and five hundred would directly contract with qualified health plans (that are subject to federal and/or state regulation); 2) All firms under size five hundred would be required to participate in alliances as the vehicle of coverage for their employees, or, 3) If firms under size five hundred were allowed to partially self-insure, they would be required to obtain adequate reinsurance and to use a state or federally qualified third party administrator that is subject to the availability and continuity and similar rules that are comparable to analogous regulations for carriers. This could at least reduce the number of regulated entities to a more manageable number.

For employers that are large enough to self-insure and opt to do so, the federal government or individual states could perform implementation, monitoring and enforcement. However, because a high percentage of larger employers operate in multiple states, it may be most cost effective and politically acceptable to have the federal government at least carry out these activities for multi-state employers.

One of the most difficult issues facing the Congress is the design of a system that both extends adequate subsidies or premium discounts so that lower income workers and their families can afford coverage and also protects the federal budget against uncontrolled deficit increases. In part to assure that the latter objective is met, the President's proposal incorporates global budget limits on health care spending. If such global budget limits are dropped, Congress will likely need to identify alternative policies to balance the need to assist lower income populations with the need to constrain federal budget commitments.

There is an alternative approach involving states that is temptingly simple and straightforward, but that I strongly believe would be ill-advised. Some have suggested that federal spending on low-income subsidies be capped, (e.g., tied to non-binding state-by-state global budget targets), and that state governments be required to pay for low income subsidy increases beyond this, (e.g., pay for subsidies associated with overail health spending in excess of federally determined budget limits.) This approach could create strong incentives for states to assure that health care costs are somehow contained to levels that constrain subsidy spending to federal limits. But it could also make financing for low income persons the ongoing political focal point for systemwide health care cost problems. Under this construct, our most vulnerable citizens would become the most likely victims of conflicts over private spending versus government limits and federally determined budgets versus state fiscal limitations and unforeseen circumstances.

In short, the approach could exacerbate many of the worst failings of the Medicaid experience and corrupt system reforms otherwise intended to make those who generate excessive costs accountable to those who pay for them.

It is widely recognized that those states with the highest concentrations of low income persons also tend to have the weakest (i.e., lowest tax capacity) economies. For example, Mississippi has the highest percentage of poor persons (25.7 percent of its population is poor, or double the national norm) and has the lowest tax capacity. (It has been estimated to be 35 percent under the national average.) The obvious implication is that it is sensible to rely on the federal revenue structure, and not on state revenue structures, for low income subsidies. Even with a federal matching formula based on per capita income, the Medicaid experience provides painful testimony to this observation.

A system which makes states responsible for subsidies needed above federal limits would hit a state the hardest if it is experiencing a disproportionate downturn in its local economy (and thus declining revenues and an increasing need for subsidies) or if it has a disproportionate number of low income persons (and thus a disproportionate subsidy costs). Similarly, a state could be burdened with high subsidy outlays because it successfully met other health reform objectives. For example, a state could experience exceptionally large increases in spending if its previously uninsured population had substantially less access to care than the national norm but it is successful in bringing their access up to mainstream standards. I do not believe we have adequate data to divine such variations and fairly adjust initial state-by-state federal subsidy limits accordingly.

It should be noted that many factors could exacerbate the likelihood that a state might be penalized just when it could least afford it. It seems highly likely, for example, that persons who become unemployed and who retain coverage are likely to increase health care service use, both because they have more time and because they "feel worse." (There is empirical evidence that this is true for mental health services.) Thus, health care spending and related subsidies could increase in a state for the same reason as state revenues fall: a weak local economy.

Just as critical is the constrained, regressive, volatile and insular nature of many state revenue structures. Public initiatives (e.g., "Proposition 13" in California) have tightly constrained state policymakers' ability to raise revenues or increase spending. Approximately half of state tax revenues derive from general or selective sales taxes? which tend to be highly regressive and extremely sensitive to economic conditions. In all but four states, the effective tax rates on the rich are lower than those on other income groups. In the ten states with the most regressive revenue structures, tax rates on the poor range from 273 percent to 556 percent of the tax rates on the rich. In these and other state, penalties to offset overruns in federal subsidies for low income persons would be largely exacted from low income persons.

To avoid subsidy costs, a state could try to reduce the health spending that exceeded federal targets. But it would be extremely difficult to sustain a system in which a state, due to its concern over low income subsidy costs, forces health spending reductions that are not supported by employers, employees, and their dependents. Provider groups would probably be effective in characterizing this approach as holding health care for the middle class hostage to welfare standards. This would generate more immediate pressure for eliminating subsidies or sharply curtailing coverage provisions for low income groups.

A more reasonable federal policy approach might be to fund any federal subsidy overruns by assessing those responsible for the excess health care costs. For example, federal law could stipulate that such a surcharge be imposed on inflationary plans that cause subsidy costs in a state to exceed federal targets. (States could have the option to adopt legislation that either constrains health care spending to that afforded by federal subsidy targets or provides alternative revenues to provide any additional revenues needed.) Such an assessment or income tax subsidy limit on could serve as an additional cost containment incentive for health plans, and could also generate the revenues needed to fund subsidy cost overruns. Since it would, in effect, collect revenue from those who chose more costly plans, it could also increase incentives to enroll in less costly plans and thus reinforce overall cost discipline. This or other approaches might create incentives for states, purchasing alliances, and health plans to stay within federal budget limits without creating a budgetary "catch-22" for the poor and for states.

I believe that if we are to achieve health care cost discipline, as well as equity objectives, the federal government must take the difficult step of mandating financial contributions. We can no longer afford the illusion that everyone can be afforded access to needed medical care without any requirement that they pay their fair share of the costs. To accommodate this internally inconsistent hope, a byzantine structure of cross-subsidies and cost-shifts has evolved. However, large purchasers have sought to contain their own costs by avoiding a share of the uncompensated care costs that are increasingly passed on to smaller payers. We have developed a structure in which it is virtually impossible to assign accountability for costs and in which the burden for cross-subsidies often falls on those least able to afford them. Federal contribution requirements and enforcement are needed to remedy this problem.

Beyond the well known ERISA preemption of states' ability to mandate employer contributions are inherent economic constraints on mandates at the state level. Many state policymakers believe that all of their residents should be assured access to health care, and recognize this goal can only be achieved through mandatory financial participation. But they also are fearful that if their state unilaterally mandates employers to finance health coverage, many firms will be at a significant cost disadvantage relative to competitors in other states. This is a particularly crucial issues for states where many residents live contiguous to a neighboring state where there is an immediate prospect. In addition, implementing a mandate will necessitate the use of substantial subsidies to ensure affordable coverage for lower income populations. As I discussed earlier, states with the greatest needs (low income populations) generally have the most limited tax base to meet them. If we are to achieve access to medical care for all Americans and protect them against catastrophic costs, federal rules and mandates, as well as federal financing, are essential.

Note: Much of the narrative on insurance regulation is drawn from *Health System Reform and Insurance Regulation*, a draft paper by R. Curtis and K. Haugh and delivered to the National Academy for Social Insurance, January 29, 1984.

## PREPARED STATEMENT OF DR. GLENN PEARSON

My name is Glenn Pearson. I am here today speaking as a physician, as co-chair of the Mn chapter of Physicians for a National Health Program, and on behalf of the Health Care Campaign of Mn, a coalition of 33 Mn organizations.

I am a physician in Minneapolis employed by a staff model HMO. I enjoy working with the HMO and believe we provide good health care. I believe HMO's have a place in a reformed health care system, and I congratulate the Business Health Care Action Group(BHCAG) for attempting to buy health care more intelligently. However, in my opinion market forces cannot solve the health care crisis. We must go beyond HMO's and employer purchasing groups and give the state and federal governments authority to eliminate waste, control costs, and help to intelligently plan our health care future.

Proponents of managed competition have touted Minnesota's health care system as 1)less costly with higher quality than the nation at large and 2)given credit to "competition" and HMO's for these presumed facts. Strong evidence suggests these assertions are false. Two recent studies that compare spending by state throughout the late 1980's found Minnesota health care costs above the national average and health care inflation equal to the national average despite high HMO penetration. This is not surprising considering the US General Accounting Office just released a study showing "no conclusive evidence exists that HMO's save money."

<sup>&</sup>lt;sup>1</sup>For example, see Hay/Huggins estimates reported in Congressional Research Service report, *Health Insurance and the Uninsured: Background Data and Analysis*, 1988.

<sup>&</sup>lt;sup>2</sup>E. S., Andrews, "Pension Policy and Small Employers: At What Price Coverage?" Employee Benefit Research Institute, 1989.

<sup>&</sup>lt;sup>3</sup>Steven Long and Susan Marquis, "Gaps in Employment-Based Health Insurance: Lack of Supply or Lack of Demand?" in Health Benefits in the Workforce (U.S. Department of Labor, 1992).

<sup>&</sup>lt;sup>4</sup>Source: U.S. Bureau of the Census, County Business Patterns, 1988.

<sup>&</sup>lt;sup>5</sup>The average per employee wages in very large firms are twice those of small firms, these federal tax expenditures are much higher for high income persons.

<sup>&</sup>lt;sup>6</sup>U. S. Advisory Commission on Intergovernmental Relations.

<sup>&</sup>lt;sup>7</sup>Source: Steven Gold, Director, Center for the Study of the States, Nelson A. Rockefeller Institute of Government.

<sup>&</sup>lt;sup>8</sup>McIntyre, et. al., Citizens for Tax Justice Guide to State Tax Reform, April, 1991.

A Lewin-ICF study for Families USA-Citizen Action, Emergency: Rising Health Care Costs in America, (October 1990, Washington, DC) produced spending estimates for each state. (The Lewin study used the definition of health care spending as the sum of HCFA's "personal health expenditures" plus administrative costs.) They found that Minnesota's per capita spending was \$2,480 in 1990 versus \$2,425 for the US; Minnesota's costs were 2.3% higher (see attached table 1).

With passage of HealthRight in 1992 and MinnesotaCare in 1993 it appears there has been an improvement in costs in Minnesota, but I assert that this is due to thoughtful planning by the state government and spending limits imposed by the state. My personal experience(and colleague's experience) is that strong pressure to become more efficient and the beginning of implementing strict cost saving interventions in HMO's clearly came as the deadline of spending limits imposed by the state approached.

Quality in HMO and non-HMO systems in Mn is good. But with the new spending limits, combined with the inability of HMO competition to save money in other areas, there has been pressure to reduce spending on direct patient care. Physicians are continually being asked to see more patients in shorter time periods and other providers are being pushed to increase patient volume by up to 50%. 10-20% of the patients I and my colleagues see each day report their doctor has left our HMO, or they do not have their own primary care doctor, or their insurance plan changed providers forcing them to leave the care of their long term trusted doctor. This is poor continuity of care. There may be short term savings by this approach but patient care will likely suffer in the long run(ultimately resulting in higher costs).

Another disturbing feature of Minnesota's health care system is the enormous concentration of power that three big health plan companies have acquired in the last two years, and the number and size of mergers and acquisitions these three have carried out since the passage of MinnesotaCare in the spring of 1993. MinnesotaCare renames HMOs Integrated Service Networks and encourages providers to join ISNs. As you can see from the attached Table 3, Blue Cross/Blue Shield of Minnesota, and state's two large HMOs -- HealthPartners and Medica -- together enrolled 49.9% of Minnesota's population in 1992.

Since the passage of MinnesotaCare in 1993, these three Twin Cities-based corporations have greatly extended their power by acquiring hospitals, hospital chains, and physician practices. In the Twin Cities area two of the three big health plan companies have aligned with two of the three Twin Cities hospital chains; Medica merged with Healthspan (a 17-hospital chain) and Blue Cross signed an agreement with the Fairview hospital system. The third large health plan company, HealthPartners, has signed an agreement to merge with St. Paul Ramsey (one of the three Twin Cities teaching hospitals).

The three large health plan companies have aggressively signed up rural providers since the passage of MinnesotaCare. Last spring Blue Cross announced it had signed an agreement with Affiliated Medical Center, which is a network of 85 doctors in 14 southwestern counties. These 85 doctors make up two-thirds of the doctors in those 14 counties. Where there competition in these 14 counties? Blue Cross has cut a similar deal with the Dakota Clinic in Fargo. The Mayo Clinic has been organizing the only large regional network in the southeastern portion of the state and will probably form an ISN jointly with a health plan company. The three Duluth hospitals are organizing one network for the northeast and will, I suspect, join forces with Blue Cross, HealthPartners, or Media.

Unless these trends are reversed, it is probable that the three big health plan companies and possibly one or two other large corporations, will, either on their own or in joint ventures with a few regional powers, control Minnesota's health care system inside two years. In rural Minnesota, this probably means one of the Twin Cities-based corporations, which are run by people outside of rural Minnesota, will control or at least dominate the delivery of health care.

To summarize: It is not clear that Minnesota's health care costs are below the national average, and it is not clear that HMOs save money. What is clear is that competition is being destroyed by mergers, acquisitions, and joint agreements.

MinnesotaCare gives us another example of why we cannot rely on free market competition in health care. There is no incentive in the marketplace to enroll high cost Medicaid patients in HMO's or other private sector providers. Traditionally Minnesota HMO's have had healthy employed enrollees and a very low percentage of Medicaid enrollees. This was inefficient poorly planned health care for the state which resulted in escalating costs and poor quality care. Fortunately, MinnesotaCare did not rely on the free market and enacted into law a requirement for providers to take their fair share of Medicaid patients. This has resulted in a marked increase in Medicaid enrollment in HMO's. We believe that a small amount of money spent on these patients to provide transportation and education, and to increase outreach (in essence preventative/ primary care) will result in large savings in the long run. Now, because of state regulation, the private sector will have the incentive to do just that.

Lastly, I want to comment regarding BHCAG. I agree that BHCAG probably gets high quality care at below average costs, but I question the leap that thus free market "competition" is the answer to our health care problems.

- 1)  $\ensuremath{\mathsf{BHCAG}}\xspace's$  employees are probably healthier than that of the population at large.
- 2) The BHCAG gets special treatment from its treating providers. This is easy to do since they constitute a tiny % of the HMO's total enrollees, but it is unclear whether the HMO could handle this same service if this were 100% of its enrollees.
- 3)BHCAG's strategy is not free market competition, but careful planning, cooperation and long term commitment between a consumer group and a provider group. This is thus much more similar to health care systems in Europe and Canada(and the community hospital experiment in Rochester, NY in the 1980's) in which local or regional boards (consumers) carefully plan health care decisions in cooperative long term efforts with their local providers and the boards regulate when needed.

To summarize, managed care can play an important role in health care reform, but it is clearly not the answer. If reform is left up to market forces a highly tiered, costly, inefficient system will evolve. Thus the state and federal government have crucial roles in reform and their involvement will continue to be crucial in our health care system in the future.

# THE CLINTON HEALTH PLAN:

# ASSESSING THE IMPACT ON STATES

by Trish Riley Robert Mollica NATIONAL ACADEMY FOR STATE HEALTH POLICY

50 Monument Square Suize 502 Portland, Maine 04101 207-874-6524

November 18, 1993

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# The Clinton Health Plan

# Implementation Issues for States

care with broad responsibilities for financing, service delivery and quality. As state governments assess the impact of reform, this guide provides an overview and a work officially with Congress on November 21, 1993 which made several important changes in the initial document. The Academy plans to issue revisions to the summary in This document summarizes the implications of the proposed Clinton Health Plan for state governments. States are currently purchasers, providers and pavers of health sheet to assist in that review. The information is based on the draft legislation released by the White House in late October. The final bill was scheduled to be filled

The Academy wishes to express its appreciation to its members -- all leaders in state health reform from both the executive and legislative branches of state governments -- for their participation in a focus group which helped structure this document; to Sara Rosenbaum, Senior Research Staff Scientist at the Center for Health Policy Research at Goorgetown University and to the Kellogg Foundation and the National Academy for Social Insurance which provided essential support for this project. However, the authors wish to clarify that any mistakes or omissions are entirely our own.

and information you would find most useful. A second paper, Health Reform: The Impact on Vulnerable Populations, assessing current state level reform and an analysis The Academy hopes to provide additional materials to state officials throughout the reform process and we would approciate hearing from you regarding what analysis of President Clinton's plan will be available soon.

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# --- The Clinton Health Plan: Assessing the Impact on States ---

# I. STATE DECISIONS

participate in the reform plan; how to of Labor to administer employer and The plan requires decisions by states standards for certifying health plans; in several key areas: how (or if) to structure alliances; how to establish managing the health budget for the greement with the US Department whether to take responsibility for corporate alliance enforcement state; and whether to seek an requirements.

## PARTICIPATE? SHOULD WE A.

The first decision states must make is if and how they will participate in the federal plan. The options are:

- participate and assume all the responsibilities outlined for states (note: states cannot design unique programs).
- implement a single payer plan

complying with standards for health

- and allow the National Health under rules of the federal bill the plan and assess taxes on be a non-participating state Board (NHB) to administer employers to finance coverage.
- WHAT OPTIONS DO WE HAVE IF WE PARTICIPATE?

8

## 1. General

enforcing quality assurance standards; creating regional alliances, certifying iffecting health plans, integrating the creating a health plan guaranty fund, within 90 days of enactment. States All states receive planning grants workers compensation insurance. must accept responsibility for realth component of auto and enforcing insurance reforms. and monitoring health plans. enforcing federal regulations

Enabling legislation will be needed in

each participating state. Once passed,

further financial support is available

the NHB by July 1, 1995 describing

requirements on or before January

how the state will comply with

Participating states submit plans to

to establish regional alliances.

assessment made against plans). The Secretary of Labor may contract with states to enforce the requirements for responsibility directly for containing nealth expenditures and if successful, he state maintenance of effort under federal savings. Penalties for failing Medicard is reduced by half of the employers and corporate alliances to contain costs are the same States may elect to assume NHB). If a state determines to create SSI) and public employees through a single payer mechanism, it must Medicaid cash recipients (AFDC, responsibilities determined by the meet most of the requirements of information systems (and other

Prescribed State Roles in Implementing Clinton Purchasing Alliances Plan Through

inder the bill.

comparable services provided through

maintain the same level of effort or

Medicaid. That is, states must

expenditure as they did prior to the

olan's enactment.

responsible for maintaining the same

evel of state investment for

purchasing alliances and are

States purchase coverage for

alliances.

for purchasing health coverage under corporate alliance. States will decide: employers are required to participate consumers are the primary vehicle the plan. Private employers of less in alliances. Employers with more than 5,000 workers may create a then 5,000 workers and public Alliances of employers and

- how many alliances will be
- what type of agencies or organizations are designated as an alliance (state agency, state appointed board or authority or non-profit organization).
- the geographic boundaries of each regional alliance which must ensure enough market share to negotiate effectively with health plans (metropolitan statistical areas cannot be split into two alliances).

A state may designate one statewide agency to serve as the alliance. A state agency could contract out some of the functions of the alliance. If a state agency is designated, decisions about the scope of the agency will be necessary. State's regulatory responsibilities could be located in a single agency functioning as an alliance or responsibilities could be spread throughout separate agencies.

Anyone with a direct financial interest in health care cannot be appointed. States may jointly coordinate alliances that contract with plans which serve residents in multiple states or providers who serve members of an alliance outside their terniory.

premiums based on the target average < 75 workers), collecting premiums Regional alliances are responsible for the federal Department of Health and and making payments to health plans providing information to individuals premium for the alliance (set by the Human Services (DHHS) related to errors which exceed a target set by using a risk adjustment mechanism determined by the NHB. States are premium discounts for low income financially liable for administrative NHB), determining eligibility for individuals and small employers negouating, directly with NHB, negotiating with health plans. ibout available health plans. discounts due low income

discounts and liability reductions for families < 250% of poverty. The financial liability is added to the state maintenance of effort amount.

gency depends on the degree of

## Comment

about alliances, requiring that they be about the process for determining the be developed and has been likened to ype and number of alliances as well arge enough to assure market share, covered by on alliance, and assuring the process of political re-districting. as their geographic boundanes. The determine those boundaries needs to plan sets forth general requirements that the boundaries of alliances are States will need to think carefully metropolitan statistical area be discrimination. The process to not set in a way that causes hat the entire portion of a

In addition to establishing alliance areas, the state needs to determine what entities will function as alliances. The decision to select a non profit or state or quasi-state

varticipants, small employer

selects a non-profit approach, the Act over the regional alliances. Although receive discounts and would need to confidentiality of information shared cost snamng requirements, states are determining premium discounts and with a non-state agency. If the state equires an employer and consumer suthonity the state wishes to exert administrative errors and bad debt ncome verification for those who epresentative Board of Directors. hat occur. States must assist in consider issues of privacy and uliances are responsible for ultimately liable for apy

Finally, many of the responsibilities of state Medicaid agencies will be absorbed by the alliances so states will need to consider whether to lay off employees or transfer them to a state based alliance or other state positions. Creation of a non-profit would likely provide more rleability in hiring alliance starf but needs to be weeghed against wider concerns.

# The Clinton Health Plan: Assessing the Impact on States -

## Certifying Health Plans

ocate providers in a way that ensures access for all populations in a service substantial impact on access to care address quality, financial stability and area. Standards in this area will have States will certify health plans, based financed from state general revenues capacity to deliver covered services. service areas and require that plans for low income and other special populations. Any state mandated penerits that exceed the national States may set requirements for on criteria set by the NHB, and comprehensive benefit must be and not from a payroll tax.

choice. Once a plan has achieved the

admission to that plan closes. Thus, procedures for enrollment. The Act

states will need to assure equitable number of enrollees it can sustain. individuals select the plan of their

payments. Plans must provide annual

open enrollment dunng which ume

community rated, the make-up of a

plan's enrollees affects premium

ureas. Because plan premiums are

## Comment

mechanisms to achieve that mix will 1/2 of the qualified health plans and

need to be developed.

distributed among the lowest priced

does require states to assure that Medicard recipients are evenly

> plans to limit service to certain areas issues of potential discrimination in services by plans, the Act allows of the alliance, thereby allowing discrimination against individuals Unless states specifically address who live in certain cities or

## Assuming Budget Responsibility idverse selection, states will need clear rules regarding plan service reighborhoods. To avoid such

The budget process is managed by

naintenance of effort payment if they tales that designate a state agency as nvolvement with the NHB on budget iverage premium below the premium managing the budget process may be he NHB. The Board must develop a spending - reviewing and approving process that allows consultation with n a better position to negotiate the representatives of states. Individual negotiations. States may, however, accept responsibility for managing idjusted average premium targets alliances and health plans. States succeed in keeping the statewide arget set by the Board. States premiums negotiated between receive a reduction in their he alliance will have direct vith the NHB.

## Comment

States are consulted but do not have

budget authority and control unless a) states elect this provision to assume uliances are state agencies, b) the state becomes a single paver or c) sudget responsibility.

## 3. Single payer option.

state. Such systems must be operated States may elect to establish a single through one alliance in an area of a egislation. Single payer plans must: designated by the state, pursuant to by a state agency or an agency payer plan either statewide or enactment of state enabling

- employer tax at least equal to otherwise pay under the plan. establish and collect an what employers would
- collect payments from federal igencies.
- enroll all individuals who would be served by an alliance.

# - The Clinton Health Plan: Assessing the Impact on States -

- may, at state option and with DHHS approval, include Medicare beneficiaries and workers in corporate alliances.
- pay providers.
- assume nsk.
- comply with the cost containment requirements (eg: average per capita premium targets).
- enroll individuals and issue health socurity cards.
- satisfy data collection requirements for alliances.
- determine eligibility for premium discounts (subsidies).

## Comment

Single payer states do not have to create a guaranty fund or certify

health plans. States are responsible for complying with budget and average premium targets. While states may decide to include corporate alliances, Medicare can be included only if meets DHHS requirements and approvals.

## C. WHAT IF WE DON'T PARTICIPATE?

States which do not participate are subject to federal sanctions. The Secreary of DHMS establishes regional alliances and the federal government assumes responsibility for other state roles. A 15% surcharge is added to all premiums charged by alliances to cover administrative costs of DHMS. DHMS may also reduce payments in a state for medical education training and public health service health research activities. However, states are freed from most operational responsibilities for plan

implementation. Non-participating states must still meet maintenance of effort requirements.

# II. STATE COSTS AND OBLIGATIONS

## A. WHAT HAPPENS TO MEDICAID?

who spend down so much for health individual, states remain responsible through the receipt of AFDC or SSI economically eligible for Medicaid Although the link between weifare and "non-cash" recipients - those and health coverage is severed, at or financing health care for these groups: "cash recipients" - those east from the perspective of the recipients are classified into two Medicaid changes dramatically. who receive welfare payments although they do not receive a individuals. Current Medicard care they become poor and weifare check.

## Von-cash

he age of the child, and certain other children up to 100%, 133% or 185% Medicaid "cash recipients." Non-cash Medicaud by Congress and the states. Medicard; instead they enroll directly of the poverty level, depending on premium discounts paid in part by state contributions made in lieu of Non-cash" recipients include the idults with disabilities) who have puzzanteed health benefit for all. states pay alliances on behalf of ininsured (pregnant women and seen recently made eligible for with alliances and qualify for The Clinton plan provides a recipients no longer receive Medicald payments.

But as comprehensive as the Clinton plan 15, 11 toosa not cover all the services now available under most state Medicaud programs such as transportation, outreach, Iranslators, and dental care for adults, (Funds are authorized under the public heauth initiative for "enabling" services.)

States shall continue to provide a residual Medical proeram for those services and in Indical povernment will operate a new program that covers essential services for children with special needs. States can create incentives for alliances and health plans to provide these services in order to enroll and effectively serve disadvantaged populations. Plans can receive added funding to provide these services but it is unclear whether federal Medical disadvantaged populations. Plans can receive added funding to provide these services but it is unclear whether federal Medical disadvantaged populations.

States will be required to provide state funds to alliances and to continue the remaining Medicaid program.

## Cash Recipients

States pay alliances a premium equal to 95% of their fiscal year 1993 Medicaid expenditures for covered services, adjusted to the year of implementation, and excluding additional payments that were made to providers who cared for a

disproportionate share of the poor.

Alliances in states with limited
untrent Medicaid benefits will receive
less than the full cost of the
comprehensive plan. The shortfalls
are passed along to the health plans.
States will continue to provide "wrap
around" services not covered in the
comprehensive benefit package for
these recipients, except that children
will now be served by the new
Federal children's program.

## Maintenance of Effort Provisions

The maintenance of effort provisions apply to non-cash recipients and children covered under the special program, who are no longer eligible for Medicaid benefits covered by the comprehensive benefit plan. A state's liability starts with the calculation baseline spending in federal fiscal year 1993 in three areas:

 Expenditures for benefits provided in the state plan that will

idjustments are based on general

be available to non-cash recipients through the comprehensive benefit

- Expenditures in the state for DSH payments for non-cash recipients.
- The amount spent by a state for services provided to non-cash children who will be served by the special children's program funded by DHHS.

The 1993 baseline amounts are adjusted by a national percentage based on the year in which a state implements the program (See table A). The adjustment process affects states in two ways. First, states who project that medicaid expenditures will grow slower than the annual and 1997 for DSH) have an incentive to implement the plan earlier. States who Medicaid costs will exceed annual increase the difference have an incentive to delay implementation. After 1998, maintenance of effort

health care inflation rate and increases in the number of people under age 65. Using a national standard adjustment percentage means that states with a low DSH amount will see their maintenance of effort increased relauve to other states and states with a very high DSH payment because of the use of a national adjustment percentage rather than a state based projection of the likely increase in these payments.

## B. WHAT HAPPENS TO LONG TERM CARE/IMPACT ON VULNERABLE POPULATIONS?

Long term care remains a state responsibility with continued Federal match. There are three major program changes, First, under Title II of the Act and not within the

Term Care Integration Option which Medicaid section of Title IV, a new, non-means tested program is created required for all states but only for a but allows a wide range of services, Disabilities (HCBS). Second, states nursing home benefit. Third, states Medicaid long term care programs nursing home coverage and are not required to have a medically needy is limited to persons under poverty and a medically needy program is may eliminate the entitlement to substitute it for a new state Long as Home and Community Based are required to continue current including room and board for nursing home program if they Services for Individuals with residential services.

Home and Community Based Services for Individuals with Disabilities (HCBS)

At a minimum states must provide an

describes the services to be provided

program. States submit a plan which

prepare the plan and administer the

States must designate an agency to

States can apply for funding under the new program and receive higher Federal match than the current Medicaid program, Funding is

services depending on funding. Since

the program is phased in, states

determine how services will be

assessment though authorization of

personal assistance services. All

individuals must receive an

assessment, care planning and

238.3 billion in 1996 rising to allocated but income cannot be used as a factor. Administrative costs are program is not an entitlement. The limited to 10% of expenditures.

There are no income or asset requirements although sliding fees are charged to people whose income is above 150% of the federal poverty level. The printed bill requires cost sharing up to 40% of the cost of services for people with incomes over 400% of the poverty level. However, the "final" version is expected to cap the "final" version is expected to cap cost sharing at 25% for people whose income is above 250% of poverty.

dressing, eating, getting in and out of

activities of daily living (bathing,

have impairments in 3 or more

due to physical, cognitive or mental

conditions or other defined

bed/chair, getting to the bathroom)

each state, to people of any age who

program provides community and residential services, determined by

Alzheimer's Diseases, mental illness,

mpairments are eligible as well.

mental retardation or physical

imitations in capacity. People with

States receive a federal rembursement that is 28% above their current Medicaid reimbursement rate but not less than 75% nor greater than 95% of expenditures up to the states allotment. The federal allotment is based on a formula which considers the number of people meeting the disability criteria, average wage for service workers and the number of people with incomes below 150% of poverty. The amount of funding is capped. The

federal allotment is increased by the federal state of Medicaid funds that were formerly paid for services to people who may now be served under the new program. The mannerance of effort requirement applies to the individuals receiving assistance on the date of enactment rather than funds spent.

Medically needy program for nursing home coverage Medically needy (spend down) programs are mandated for institutional long term care only. States that can reduce the rate of growth in long term care expenditures would benefit. The flexibility to shift funds to residential and community care allows states to expand services if they can reduce the supply of nursing home bods or reduce occupancy rates by Medicaid received.

## Long Term Care Integration

new program, into a block grant. The capped at the amount provided to the combine all Medicard long term care olock grant eliminates entitlement to Congressional sponsors dropped this program. Note: The bill as filed by meet the impairment criteria of the Medicard recipients, Unlike current nursing facilities and ICF-MRs for (determined by the secretary), and adjusted based on expected rate of aw, reimbursement for room and The Act gives states an option to programs, for people who do not state for services included in the board in residential settings, not otherwise federally reimbursed. natching. The federal share is growth in the absence of the would be eligible for federal program during a base year

# Other long term care provisions

Demonstration funds will also be

available for states wishing to experiment with programs that integrate acute and long term care for those receiving both Medicare and Medicare.

The provision of private long term care insurance may increase with the Act's provisions for tax incentives. States must issue new regulations that combity with federal standards governing private long term care insurance. It a state fails to submit a plan or the plan is not approved, no private long term care insurance private long term care insurance policy may be sold in the state.

## Medicaid Comment

States appear to remain responsible for long term care and other optional services outside the Act's comprehensive benefit (eg: currently optional Medicaid services) for non-cash recipients. Of the 24 million Americans receiving Medicaid, 6 million are "non-cash" recipients, many of whom are in nursing homes. The new Federal Children's Plan is

not yet well defined and will not cover long term care. In addition, the Act's roquirement that home health and retabilitation services be provided to those who are in need due to an illness or injury does not cover children who are disabled at birth. While Federal match will be available for long term care. It is not available for the non cash recipients who requires services beyond the new comprehensive benefit.

States will benefit, however, from the higher Federal match available for the new Home and Community Care Program.

Determining state maintenance of effort and expenditures for premiums for Medicald recipients will be a challenge for states and will ruse issues of interstate equity. For example, full premium discounts are only available for those Medicald recipients who are eligible for AFDC or SSI. Because state eligibility levels or SSI. Because state eligibility levels vary greatly, state liabilities will also vary greatly. A NHB committee will

nealth programs) will now have those Public providers could be designated as essential providers by DHHS and be convened to examine methods to determining the state's maintenance educe or eliminate these variances. matching current state expenditures of effort requirements. Because the ramifications of these requirements. receive funds through alliances and available to pay to an alliance and spent in mental health or school tate match is money supporting existing programs, it is not cash ntergovernmental transfers (eg: states will need to analyze the aggressively sought to create Likewise, states which have expenditures "counted" in

# III. WHAT SHOULD STATES DO NOW?

The President's plan and anticipated Congressional action make it challenging for states to plan the appropriate steps to take toward reform, particularly since the current proposal from the administration does not allow states discretion to craft their own plans unless they are for single payer systems. Because the President has made clear his willingness to compromise as long as universal coverage and cost condiamment goals are achieved, states could consider several actions now:

- Assess the implications of a single payer policy compared to the managed competition proposals to determine how the state wishes to proceed.
- 2. Examine current data systems to assess capacity to determine

current health expenditures, quality of care, and health status and project the impact of competing national proposals. Analyze how many different agencies collect what kind of data.

- current Medicard expenditures mental health or public health. are those dollars available and requirements through existing state determine how much of project maintenance of effort financed. For example, if a purchasing alliance? Can a carticular attention to how accessible to transfer to a Analyze current Medicaid program expenditures for expenditures for cash and are spent on the services dentified in the national non-cash recipients and requirements, paying Medicaid is currently tate meets matching benefit plan? ٣,
- Review and assess ability to comply with standards for quality assurance; information systems (e.g., cost implications, existing capacity for data collection, surveillance, outcome monitoring and enforcement functions).
- Consider existing enforcement capacity to ensure that providers, clinics, hospitals, long term care facilities, laboratories and allied health providers meet established standards through licensure, certification and inspection.
- Assess current health care
   work force information (e.g.;
   number of residency training
   slots per specialty area;
   medical school commitments
   to primary care; recruitment,
   preparation and retention of
   primary care providers.
- Encourage the formation of a

greater range of managed care networks to deliver existing benefits.

Determine organizational

- Assass which agencies do what activities today and what needs to be done to implement reform. If purchasing alliances are to be established, assess implications of different models (non-profit, state agency, quast-governmental board or authority). Consider which state roles will now be transitioned to alliances and how state employee contracts will be affected.
- 9. Review how state employees and retures now purchase health care and consider developing purchasing alliances prior to reform.
- Examine the unique responsibilities of states for vulnerable populations who

often require additional service beyond the newly proposed standard national health benefit.

a. review organizational readiness to implement a new home and community based services program for all ages; b. review policy options for shifting long term care resources from institutional to community and residential service models;

c. consider the impact of replacing the medically needy nursing facility program with the "block grant" option.

- 11. Draft enabling legislation and prepare application for implementation grants envisioned in the President's proposal.
- 12. Assure a focal point, across agency lines, in state

government to conduct a comprehensive review of competing proposals and proposed amendment.

A number of states are considering Medicaud expansions in 1994 but may be concerned about their increased manntenance of effort liability. Other states may consider cutmng back eligibility to reduce their liability.

The bill specifies federal fiscal year 1993 as the baseline year and prohibits states from reducing eligibility in 1994. There is no guarantee that Congress will not change the base year to 1994. States may consider creating a program expansion using what would have been the state matching share of a Medicaid expansion as an interim measure to expand coverage without rising increased maintenance of effort liability. Medicaid expansions that attace effect in federal fiscal year 1995 that a slab be considered.

Finally, states have considerable experience in the purchase, delivery and financing of health care as well as in its reform. States would be well advised to engage all interested parties in discussing reform to assure that this opportunity for change reflects the needs and capacities of states — their critizens, providers, payers and policy makers.

--- The Clinton Health Plan: Assessing the Impact on States

7	requirements for non-cash recipients and DSH payments	on-cash recipients	and DSH paymen	ts
	Cash Recipients	pients	Non-cash a	Non-cash adjustments
	AFDC	SSI	Non-cash	DSH
1996	32.2%	29.4%	89.98	45.9%
1997	46.6%	43.7%	78.1%	61.8%
8661	62.1%	58.8%	102.2%	79.0%

--- The Clinton Health Plan: Assessing the Impact on States ---

	Who Pays	Who Pays For Medicaid Changes?	
Change	2011	Federal	Commercia
AFDC + SSI Cash recipients	State pays 95% of 1993 (adjusted) state expenses for services to the comprehensive beanti previoually covered in state Medicald program.	DHHS pays 95% of federal share same as state.	Calculating cost of benefit not easy as Medicaid service definitions differ from guaranteed benefit.
AFDC + SSI benefits outside plan	State provides wrms around breseit for all but special needs kids and browdes managemance of effort payments to DHHS for new children's proverage.	DHHS continues federal match. DHHS pays 100% for special needs kids in poverty. Services through plans.	How will chatbility be determined for 1 programs (Alliance plan, rendual Medicaid & special kids program)?
Nos Cash recipients	State calculates MOE for cost of guaranteed benefit and pays alleace.	DHHS provides funds to alliances to cover premium discounts to non Medicald poor (formerly non-cash Medicald recipients).	Does state continue residual program for non-cash? If so, how funded? If not, is it a "windfall?" Who provides residual services? Is it a state liability without match?
Medically needy	State continues medically needy program for nursing homes and ICF-MRs	Federal match continues	What happens to medically needy services other than narrang homes/(CF-MR?
HCBS	State initiation over program with 5-25 % case match. Existing 2176 waven condition.	DHHS match at 75.95%	States receive potential "windfall." Can transier 3 ADL Medicad recipients to new program with higher match. States will receive FFP for existing general revenue programs for some participants.
Optional block grant	States can combine NP, ICF-MRs and home care. Not an entitlement service, Match remains the same. FFP for room and board in residential extines allowed.	Use current Medicald marching rate with cap on rotal FPP based on base year spending adjusted by projected growth in absence of program.	Could stakes see asvings if nursing home growth or number of recipients are reduced? DHHS defines residential settings.
Personal needs allowance	States pays current PNA resis	HHS pays difference between current rate, if lower, and \$70 per month (may change to \$50 per month).	Federal government раув вхіта сонія.
рен	DSH for non-cash recipeeds is part of mannersace of effort.	Federal DSH payments capped at \$800 million. Formula allocation to hospitals.	
Asset limits	May increase protection to \$12,000 for individuals in institutions		Increase states costs by exampting additional resources from Medicald spend down requirement.

## STATE WORKSHEET:

## ASSESSING THE IMPACT OF THE CLINTON HEALTH PLAN ON STATE GOVERNMENT

Activity	Robes for States	Name Berd Aliens	Albimos	1	Private Section/Individual	Fotorsi Agencia
Semiri	Sime may add manualed been been to transfer to transfer to transfer with case revenue; calent we emprove them tax, identit on integrance of means bearing a recommon ames or 1995.	Promertee emerit (no infectore design materials).  May retra and and to besent man and and to besent man and to besent man emerit emeri	Procures assurint too infection   Procures of the plant to deliver beneating the plant to del	Must promae compression to beautiful autientical approved employmental beautiful	Eliminates committy to incluse hault in careera news seems affections and provine and stocket for the definitions.	identifies curcumstances unesewhere allumons unest contract with "censers of expellence", appearing besuith commers
2. Booker	NRB creases a revew and communic process that includes one representatives.  Sinks may want remonshiptor for managazing restorate one for managazing restorate one for managazing restorate one for managazing restorate one forms to restorate managazing restorate to enforce previous managazing of effects previous of effects and previous managazing of effects previous and previous an	Som manages a vertica per common personal personal common personal personal companies and personal per	Negociame eventums with passe writin target set by M-B	Allumba	Coroceas adiamos resonante for coercing presida	DOL esterona emperorer and corrorms animation response bilities
3. Parameter	Administration discussions of editors (non-basines).  Perve sistements 50% of venegitable servines personally to elements and agency to contrast personally to contrast personal personally to contrast personal p	Emissions rut artetiment memoranosory for luga rut. memoranosory for luga rut. memoranosory for luga rut. Cartifina leniget compression.	Collects pressures Administration To any Pressure benefit care Protection Colories pressures to price agreement to price any any any so that not been unemanded to price any so that any so the service and selectricities to covery test debal.	Акорева или паминува тик	Pere allumine 80% of the control of	Secremon of DOL, provides againstone to cultercome activations to cultercome activation of the cultercome of DRES with DOL. & Treasory of pressions amounts for memory against framero.

Federal Agencies	HIS limits growth of Medicare and Medicard	Pideral government pays 30% employer slams of non- Medicare sligible seary retress age 55-65
Private Sector/Individuals	Provider frees restoosed if plan excessed premium tarpst Cost abaring requirements (see belows)	Firmstrindivrudable mast supply to alliances. Submidies for firms < 75 \$24,000  Lodivoltus & femilies < 150% quality for presuma discount.  Femilies < \$40,000 pay no more than 3.9% of incomes.  Femilies < \$40,000 pay no more than 3.9% of incomes.  Accordance with incomes < 250% of porverty recen we makedly for \$0.5% on porverty recen we makedly for \$0.5% or porverty to larve for the continues and the presumant, underest 100%.  Con alterning relationed for < 150% of porverty to larve for < 150% of court whatter amounts and AFDC & SSI recipieses pay 20% of court whatter amounts and court of the court whatter amounts and court of the court
Phase	Penalized if rease oxceed bodget	Mus collect cost abenta for all pertecpants.  Amounts for non-workers below 250% of powerty, alidita scale - unemportment benefits, public assustance pertecting is \$1000 in income disregarded.
Affances	Negotians with plans for fravorable rains Can deay contract to plans whose pressures exceed 120% of weighted average pressures	Descrizione supplitity for discourse.  Reconciliatore of income statementa at yest-rest.  Veriance in discourse to complete complete and permit.  Alliance mest collect bad debt and add one and a series of plasmed very contamination of the additionaries and restrictions in a plasse presents and restrictions for discourse and restrictions in contamination.
National Board	Sees enforceable premium growth cap Limits on allowable sedministriate costs	
Roles for States	May set fee for service raise  Must establish captual requirement for place Situde payer states automato reduction to provider payments if expenditure largue excesseda	Stakes financially responsible for excess administrary scale along givenism discounts for low incomes individuals and employers
Activey	4. Cast coestrol	5. "Discounts" (subsidies) for lew income undryduant and complayers

Federal agencies		Enforce transitional reforms that provide guaranteed renewal, no cancellation, portability, limits on premium increases.		DFRK must approve plan.
Private sector/individuals	No ionger selecta plaza for employees.  Corporate alliances conduct erroilment, marketing and provide choice of plaza.			State option to allow corporate alliances to continue outside single payer plan.
Phase	Must enroil all regardiess of age, condition, cost. Market directly to consumers purcaant to aliance rules with prior approval of maserials. May limit enrollatest due to capacity or financial stability.	Must submit community rated premiums once state implementation begins (1996-1998).	Plans that cross scale littles may meet uniform aliance requirements as set by states.	
Alliances	Enrolls eligibles, governs plan marketing, provides consumer information, establiabes premium discount/"subsidy" levet.		May coordinate, subject to state approval, operations with alliances in neighboring states.	State aspency must be desagrated to operate trainwords snaige payer plan; case may desage an alliance to operate angle payer in one region of a state
NATB	Sea rules for enrollment and marketing. Revrews and approves state systems. May require additional captal for plans based on provisited enrollment and supply of providers.	Develops rules to probabit markeing abuses or disclosure of personal information.	NHB creases commence or regional versations in health epipentiaries with goal to eliminate versations in spensing for cash recipents in bedget neutral masser (and other versations) by 2007.	Approves state stagle payer
Roles for states	Transtron Medicard, public employees, retirees to aliance.  Add Medicare coverage of state employees it not now covered. Plans may enroll Medicare if state receive DHIS approval.  States may provide incentives for plans to enroll disadvantage of routes.	May enforce traumings reforms under agreement with DHHS.	States may set rules permitting alliances in two or more states in or coordinate operations (adopt joint operating rules, beath plan continets, celloreseeth provisions and unified (se schedules.	State option to include statewide system or single payer within an alliance region.  May include Medicare, with DHSS approval and corporate alliances.  Must be responsible for complying with statewide average premium stayes and other budget requirements.
Activity	R. Enroldment and Marketing	9. Insurance reform: transitional rules	10. Inter-state immes	11. Single payer option

Federal Agencies			Administration and administration of effort requirements. Federal DSH Payments capped authorizing a foreign a hospital in few income percentage and 25 % for earwices not covered by Act.  DHIS establishes new low income special passes in income special passes children a program.	
Federa			Administrational and informational DSH Paymens authorially. Allocation to reflects a hospital's low reflects a hospital's low reflects a hospital's low reflects and covered Act.  DHHS enablishes over I income special needs children's programs.	
Private Sector/Individuals	Cash assistance recipents only subsidized in low cost. HMO/PPO plats. Only provide fee for service plan if no low cost plan available.	Not covered: Medically needy adults (non-nurang home eligible), pregnant women up to 185% poverty, working disabled without cash benefit.		
Plans	Must serve all low income paces who select a plan. Plans collect premium copsyments. States may contract with plans to provide long term or coordinate long term care and acute care services.			
Alliances	Enroil cash and non-cash recipients and determine and cost sharing discounts.  Need to develop protocols for portability of coverage since low income people and the first mobile and are not requistly attached to work force.  Determine eligibility for premium discounts.	Need protocols to integrate alliance coverage, foderal children's program and readual Medicaid services.		
National Board	Establish rules and mantenance of efforts requirements.  Establish consumer cost abanne requirements which are higher than allowed under present Medicaud law.  Probibit plan diserrimination against low income.			
Roles for States	States pay premium for base benefit for AFDC & SSI statements that extends 95% of the states. Medicand expenditure for benefits in package.	States no longer responsible for care to non-cash recipients except for maintenance of eifort payment.	1. States pay lump arum to alliance to base on 2002, expenditures as 1993 for non-cash respicate for state plan benefit in comprehensive package, adjust for year of package, adjust for year of package, adjust for year of DSH expenditures for non-cash respients, adjusted for year of state implementation.  3. States pay DHHS for easien implementation.  3. States pay DHHS for easien expenditures for special childrens program.	
Activity	Cach retpients	Non-cash recipients	Maintenance of effort	

Federal Agencies		28 % iorromen to Medicand mateinag rate for new program (mananum 15 % & maximum 95 %).
Private Sector/Individuals		
Phaes		States may contract with plans to provide long term care or coordinate long term care and ects care services.
Alliances		
National Board		
Roles for Nates	Mantan long torm care benefits for special needs children and other populations Mantana obitation to provide enabling supplemental services not included in comprehensive benefit. May be delivered through incentives to alliance through incentives to alliance and olass or through public health initiatives.  Pay supplementary natrance premiums for elderly & dissibled recipents who are eligible for Medicare.	Serves poople of all ages who have 3 or more ADL or other impairments.  Provides assessment, care plan and personal assistance plus other services included in a stead plan.  Not an embildencetic rasses see policy or promoty for funda (cannot use incomes).  Coes daaring up to 40% of coes of services above 400% of coes of services above 400% of poverty (may be changed to 25% above 250% of poverty).  Maintain Medicand LTC  ADLa or adopt integration oppose.
Activity	Residual program	13, Long Term Care New Home & Community based care programs

Federal Agencies	FFP capped at base year plus capped at base year plus capparation using protected appearation.	DHHS pays difference in perronal coats allowance (PAA) in nurang bornes between sats levet and S70, if lower, (Revrend to S50).  DHHS est rules goverumg prymes long term care insurance; HHS provides state grants to enteron rules.  Examine to enteron rules.  Examine to enteron rules.  State results available to worting skells with dissibilities @ 50% of cost of dissibilities @ 50% of cost of the state of t
Private Sector/Individuals		Employer financed private long term care insurance premems are ax deductible.
Planes		
Alliances		
National Board		
Roles for States	State may elect optional "block grant" program and provide expanded home and community care.  Eligibility is greater of 100% gloverty level or state SSI payment standard.  May caah out oursing home bay cannot be and can number of beds, but must into trogram to low income Medicaid recipienta.  May reliade noom & board or come of the state of	Mandatory modically needy (spend down) process not nursing, homes and ICF-MRs.  May increase assets allowance for individuals up to \$12,000 States may enforce foderal policies
Activity	Long Terra (are "Block Graud" Option (may be dropped from itaal draft.)	Private long term care insurance Tax credits for captored people with disabilities

Activity	Roles for states	National Board	Alfances	Ples	Private Sector/Individuals	Federal Agencies
14. Public Health and creental providers	Continue core public health roles (wester and air quality, disease preventron, health ed, collect and analyze dess).  Administer public health greats (school clinica, rural health).  Retain core public health health (unctions including collecting and analyzing data.  Administrative costs limited to 10%.			Must contract with 'essential providers' for five years; estential providers will samet in determining eligibility for new 'Medicale replacement program' for special needs children.  No cost shanne for preventive care.		DHHS Secretary determines tress of payment for plans which must pay actood health, providers. Automatically designment o-secolal community providers "including migrast beautic centers, family providers "including migrast beautic centers, family providers which of the health, maternal, and child health programs, echool health programs - so sais role; other providers may be designated.  Grazzs for enabling services & other public beauth instantives.
15. Quality Assurance	Crievance board after local remedies exhausted; retains discussing of providers, destruction or alliances and quality of plan.  Consults with NOMC to develop national remeatres of quality performance.  May add survey questions on quality messarres of local interest.	Sees exactants for QA and data collection.  Establishes and overnees performance bessel program of quality management and improvement.  Neticonal Quality Management Council with 15 members appropriated by the President to:  Conduct perrodic serveys of consumery:  Establish goals for perrodic carveys of consumery:  Establish goals for performance of plane;  Provide Congress with assessed quality management reports.  Establish utilization	Responsible for commenter information, ombideman/grievance (niscinor.) Publish annual performance report based on national measure. Dissentions comment information. Responsible for quality and performance standards.	folestraal QA required.	Commit with NOMC on development of nahonal measures of quality performance.	AMCPR, WIH and MCFA included in developing pattornages of quality performance.

B Foderal Agencies	Grants to providere (to state root) to develop qualified community health plans and precious referrable  DHHS are number of training porntone in secta speciality.  DHHS aspoints 10 regional controlls to allocate GME training alotts.  National Control on Oradinate Mestical Education sets minister of speciality pointions.  Responsible for animal beauth protessions workforce accounts.	Serverance of DOL, HHS cream commission or cream commission or cream commission or beautiful beneafile.  DOL prescribes rules or design or province or workers companies or province rules.  DOL & HRS may fund state demonstrations.
Private sector/ladividuals	Medical readences will be allocated by regional corrorls.	Workers comp and enter current construct with plan.  Individuals receive services through plans.  Curriers man file report on changes in presistant with sale writin 6 months of essertment.
Phase	Oceal to crease a new beaith workforce, skift balance as graduate transmit from appetuity to primaring from appetuit and physician assessments. Until primaring assessment as meeting balanch & substance alsues control of violence.	Provide for workers comp via apparal providers; mais have case natistages.  May negociate alientative payment metabod.  Mear refer for appropriate medical treatment as beaded.
ABlemos	Pary DHMS 1.5 % of presumes coleicuse to pery for Orinitaes Medical Education and Academic Health Carsers.	Extendinates froe actionalists for workings comp and auto cannot.
National Board	Commiss to 5 year phase in of 55/45 mix prinsery of 55/45 mix prinsery of specialty care; phases out hadeciers and Medicinal payments for Offile and replaces with pooled funds from inserent.	
Dalla for many	Workforce plemning for beauth provincesconais.  New community training programs for tural programs for tural	May onecotase alternative perviser methods for these cont.  Man coordinate access to specialized workers comp providers on behalf of plans.  State may not restruct choice or specialized workers comp yourseas of providers providing workers occupated to coordinate payment of workers occupated behalf insurance privated behalf insurance privated behalf insurance privated.  Resert to DOL on rea fillings
A section	16. Medical elecation/ pressury care expectly	17. Integration of workers componentation and note tomerunce

Federal Agencies	HRS establishes all prover beauth care frand and seless control program.	Included			DOL, DHHS epposes		DHHS expount nemonal commutities	DHHS appoune 5 member board.	DHHS appoints	DHHS apparate		
Private Sector/Individuals	Limits on jawyer's fees to 1/3 of areard. Researce individual to have certifician of mert before sessing court actors.	Included	Providere included but not consumer	Constance, comployers, providers included		Providers, consessers included				Not included	Comments, employers, providers included	
- New	Plans must eenablish alestrative dispuse resoletion process.	Included	Excluded	Incroded						Not instituted		Included
Alliences		Inchaded	Included	Íncinde						Not included	Nehates	Required to appoint from participating providers
National Beard		Appoints continuities	Арроцию совинитем	Арроция соминиве	Membership not specified					Pederal employees included	Appearts committee	Incheded
Roles for states	Establish onterprise liability denomination projects; may not apply state area re: corporate practice of medicine and provider overseming of health plans or providers to managed care plans.  Eliminates state law Plans.	Included on committee	Included			Not included	Required in each state, Broad representation, appointed by governor	I state division of insurance commissioner appointed		Included	Incitoded	Included
Activity	18. State corporate prenctice: Medical mathyractice: Franct & steme	19. Advisory besies Health Deca	Quality Assurance	Risk Adjustment	Integrating health benefits	Graduate Medical	Long Term Care	Private LTC Insurance	Breeichrongh Drugs	Medicard Commence	Provider Advisory Bosrds	Repond Expenditure Variations

			100		Private Sector	Pederal Agencies
Activity	Roles for states	National Board	7			Proteibits states from restricting
20. Licensers and continues	Responsible for licensure and certification	Creeks uniform national considerate				practice of any class of providers
21. Enforcement Promition fled of year recorreliation for greenless discounts	State provides income verification information againmally to FIMS	Seas orrur rate simplantes	Mean recounte deincounte and income semente. Collect creepayments and possibles (except forMedicand recipeess)		Individuals not eligible for discourse union statement filed. P alse information requires requirement 51.000 files or three times excess payment for insectional marrays researches.	DHRS on possibly rate
Pallure of alliances to pay plans	Stems semblishes guarusry fund; Should alliamose full, may assess other allianose 2% if one fails.	See a sample of	Pays use generally fram	May terustana coverings of alliance or corporate alliance fails to pay. Sate tast was measure measurement of failed plan	In case of plan fullway, seeing pays providers darectly	
Painre to mest budget	States may be designated to manage budget exformesses.		Plane ment rection payments to providers of bedget asconded			
State failure to meet manneause of effort payment		NRB overagis; cannot change amount of psystems required from a state				
22. Treesment of		Not covered in plea				

Senator DURENBERGER. The committee is adjourned. [Whereupon, at 1:25 p.m., the committee was adjourned.]

# GUARANTEED BENEFITS UNDER THE HEALTH SECURITY ACT

### FRIDAY, FEBRUARY 4, 1994

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 9:57 a.m., in room SD-430, Dirksen Senate Office Building, Senator Jeff Bingaman, presiding.

Present: Senators Bingaman and Kassebaum.

#### OPENING STATEMENT OF SENATOR BINGAMAN

Senator BINGAMAN [presiding]. We will go ahead and start the hearing. Senator Kassebaum is on her way, and we will interrupt things and let her give a statement when she arrives. But let me just welcome all the witnesses. Senator Kennedy is occupied on the Senate floor with the "Goals 2000" legislation, and otherwise he would be here. We will include his statement in the record.

[The prepared statement of Senator Kennedy follows:]

## PREPARED STATEMENT OF SENATOR KENNEDY

Today the Committee will consider the core of the President's Health Security Act, the guaranteed benefit package, the guarantee at long last of comprehensive health benefits for all Americans.

The first essential step in health reform is the promise of universal coverage. But that is an empty promise if the benefit package fails to protect Americans against high medical costs, whatever their illness or injury. The benefit package must not perpetuate the current fragmented and inadequate approach, which often provides care only after people become seriously ill, instead of preventing illness in the first place.

We are all aware of the increased costs—financially, physically, and emotionally—when treatment comes too late. By ensuring that all citizens have comprehensive coverage, we guarantee that they will have true health security. No matter how rare their disease or how expensive their treatment, they will be covered. For true security and piece of mind, everyone must know that this protection is

there for them and their families.

By guaranteeing preventive and primary care, we encourage citizens to seek care early—when treatment is often less expensive, and recovery more likely. Comprehensive benefits will also enable providers to develop the most medically appropriate and cost-effec-

tive treatments for their patients, saving dollars and saving lives

in the long run.

Some argue that a bare-bones, stripped-down package is all we can afford. But cutting back the benefits will create cost-shifting, not cost-savings. Employers who offer a comprehensive package will be forced to continue to subsidize those who offer less. The costs of uncompensated care for those with limited benefits will be unfairly shifted to others, and health reform will fail.

To those who say we should offer only limited benefits, I ask—what medical services will you exclude? Will you exclude prescription drugs for the elderly? Tell that to Clifford Townes and his wife in South Dartmouth, Massachusetts. They have watched their \$100,000 in life savings disappear—devastated by the high cost of

prescription drugs.

Do you want to exclude mental health benefits? Tell that to the millions of Americans and their families suffering from a mental illness who do not understand why mental illness should be treated differently from physical illness.

Will you exclude dental services for children? Tell that to the children who suffer for a lifetime from poor dental care and un-

treated dental problems in their early years.

Will you exclude preventive services? Explain that to mothers who wait and worry until their children are seriously ill before taking them to the doctor, because well-child visits and preventive care are not covered.

Will you increase the patient's share? By raising deductibles and coinsurance and out-of-pocket limits, middle class Americans will be discouraged from seeking the care they truly need and low-income Americans will never have access to the care they need.

Some argue that the President's plan is a Cadillac plan, and say we cannot afford it. As we will hear from one of our witnesses today, President Clinton's plan is precisely what the vast majority of employers now offer to their employees. Those businesses want to continue to offer such benefits. The benefit package in the Health Security Act is not a Cadillac. It is more like a mini-van—a reliable, solid, safe vehicle for all the members of the family. Let's not turn it into a broken-down second-rate car that will let those families down when they need its protection most.

Opponents will also argue that we should avoid this entire benefit debate. They maintain that discussions on the benefit package should be left to a board or commission to be appointed in the future. As we will hear today, the American people will not stand for that. Consumers want a comprehensive benefit package specified in

legislation.

The benefit package is the heart of universal coverage. A health care reform bill that does not specify the benefit package is a hol-

low bill that misleads the public and jeopardizes reform.

The goal of the Health Security Act is to legislate for all Americans the kind of benefits that the most responsible corporations offer today—and that Congress has already legislated for itself.

We must reject the temptation to strip out necessary benefits. The American people expect better from us, and we should expect

better from ourselves.

I welcome our witnesses, and I look forward to their testimony.

Senator BINGAMAN. This is a hearing on the benefits package that is proposed in the President's Health Security Act, and general testimony as well on alternatives that should be considered

with regard to the benefits package.

Let me just introduce the first panel, and we will hear from them in this same order. Ed Hustead of the Hay Group is working with the CRS to analyze the cost of different benefits proposed in the Health Security Act. He will discuss how the benefits of a typical employer-based health plan compare with the comprehensive benefits proposed in the Health Security Act.

Margaret Jordan is vice president of health care and employee services for Southern California Edison. Southern California Edison is a member of the Washington Business Group on Health, the National Leadership Coalition on Health Care Reform, and the Business Roundtable. Ms. Jordan will discuss Edison's experience

with providing comprehensive benefits.

The final witness on the first panel is Dr. William Straub, who is associated with The Jackson Hole Group. He is from Westport, CT, and Senator Dodd wanted to be here to introduce you for that reason; he may also appear as we proceed through this hearing. Dr. Straub will discuss his ideas about phasing in benefits over time.

We appreciate you all being here. Dr. Hustead, please go right

ahead.

STATEMENTS OF EDWIN C. HUSTEAD, SENIOR VICE PRESI-DENT, HAY/HUGGINS, INC., WASHINGTON, DC; MARGARET H. JORDAN, VICE PRESIDENT OF HEALTH CARE AND EMPLOYEE SERVICES, SOUTHERN CALIFORNIA EDISON CO., ROSEMEAD, CA; AND DR. WILLIAM H. STRAUB, WESTPORT, CT, ON BEHALF OF THE JACKSON HOLE GROUP

Mr. HUSTEAD. Thank you very much, Senator.

As you said, I am with the Hay Group, and we have a large private sector consulting organization, working with our clients to consider the factors of health care reform, as well as with the Congressional Research Service.

I have provided testimony for the committee, and I will summarize it briefly, pointing out the key facts of the differences in the S. 1779 benefit structure and those of the private sector, and how S. 1779 might be modified, either to liberalize the benefits or reduce the cost of those benefits, and what impact that might have.

On page 7, I have presented a table that compares S. 1779 to the typical private sector plan, both in our own survey and in those conducted with the Bureau of Labor Statistics. As you an see, and as is not surprising considering the way the benefits were developed, in many respects, these are quite similar to those benefits that are in the private sector. The requirement for the copayment is that the individual pay to the first \$200 and then 20 percent of any remaining part of the bill up to a maximum of \$1,500. This is a very typical design and in fact, the average design in the private sector. It covers hospitalization, surgical, x-ray, prescription drugs, and preventive care.

The areas where there are significant differences, which are quite important both in policy and cost, are in the prescription drugs area which requires a separate \$250 deductible, which is not normally found in the private sector. Preventive care is covered under the bill at 100 percent by the plan. Typically in the private sector, preventive care when it is covered is covered at the same

80 percent rate as other care.

Inpatient mental health and outpatient mental health is an area where the bill does differ substantially also. In S. 1779, there is a phased-in program in the year 2001 which provides equal treatment of mental illness with other illnesses. But even in the initial benefits before that happens, in the initial benefits being proposed for 1997 and 1998, the plan provides the same floor of coverage as in the private sector—30 days of inpatient and 30 visits of outpatient—but in addition provides care where medically necessary beyond those points.

Finally, an area where the initial benefits are below those in the private sector is in dental care. The initial package only provides dental care for children; the phased-in package provides full care for adults and children. Most large private sector plans provide full

dental care for adults and children.

When we put all of those elements together and compare the value of the package to those in the private sector, we show that in the table on page 3. If you compare the initial benefits of S. 1779 against large plans, State and local, or employer plans in the private sector, it is slightly below average. The reason it is below average is because it only provides children dental and not adult dental. Compared against the small employer market, it is above average because fewer small employers provide dental care.

Senator BINGAMAN. Is this in the chart on page 3?

Mr. HUSTEAD. The chart on page 3, yes.

Senator BINGAMAN. Could you explain that chart a little more?

I am having trouble understanding it.

Mr. HUSTEAD. Yes. This says that for the initial S. 1779 plan, before you bring in the adult dental and the improved mental/nervous in 2001, that this plan is more valuable than 58 percent of the plans offered by small employers in the United States. So it is above average when compared to the plans offered by small employers.

When compared to medium and large employers and State and local employers, it is at the 45th percentile, which means it is somewhat below average, because while it does have better benefits in preventive and mental illness, it does not provide adult dental

care.

Senator BINGAMAN. So it is better than 45 percent of those plans in that category, but worse than 55 percent.

Mr. HUSTEAD. Worse than 55 percent; correct.

Senator BINGAMAN. OK.

Mr. HUSTEAD. When we look at the phase-in benefits, which include adult dental and the mental and nervous, full treatment mental illness, it is more valuable than three-fourths of the plans in either the small or large segments. So the proposed phased-in benefit is more valuable than most plans that are available today.

Senator BINGAMAN. That is because of the dental?

Mr. HUSTEAD. Because of the adult dental; the adult dental is what brings it up above average.

Senator BINGAMAN. That is the main distinction between the two that you are comparing.

Mr. HUSTEAD. Between the initial S. 1779 and the phased-in

plan in 2001, yes. That brings it above average.

Senator BINGAMAN, OK.

Mr. HUSTEAD. The other aspect we looked at is shown on the table beginning on page 5, looking ahead to the debate in the committee and through Congress this year, as to how could this benefit package be improved, and what would that cost, and how could

savings be achieved, and what would that save.

We look at various elements of the package. Now, most of the increases in cost and savings relate to the amount that the enrollees and their dependents are required to pay, their copayment, because obviously, the more that you require the enrollees to pay, the less the plan has to pay, and on top of that, if you require the employees to take a greater share of the bill, they will use less care. So

there is a double savings if you increase the copayment.

On the first item, we look in two directions on the coinsurance where the employees are required to pay 20 percent of the cost. There are still many plans around in the United States, those fourth of the plans that would be more valuable than even the phased-in S. 1779, which provide 100 percent coverage on hospital and surgical. If you were to take S. 1779 and cover 100 percent of the major bills, hospital and surgical, you would increase the cost of the benefits by 5 percent.

On the other hand, if you were to cut, say, the 80 percent coinsurance down to 75 percent and require the employees to pay 5 percent more, then you would decrease the cost of the plan by 6

percent.

Raising and lowering deductibles does not do a lot. There are minor savings unless you make major changes in the deductible. If you were to take the \$200 the employee has to pay and reduce it to \$100, you would increase the cost of the bill by 2 percent. If you were to increase the deductible to \$300, a level that is commonly

found, you would save one percent.

There is a limit in the bill and in most plans in the private sector beyond which the employees are reimbursed at 100 percent, and that limit is \$1,500 a year. If you were to lower that limit to \$1,000 and make the employees pay less, you would increase the cost of the plan by 3 percent; if you were to raise it, you would decrease the cost by 3 percent. So changing the limit at which the employees stop paying anything, and the plan pays the full amount, has a substantial impact on the cost.

I mentioned earlier that the S. 1779 provisions are unusual in that they cover preventive care at 100 percent. If you were to cut that preventive care coverage down to 80 percent, then you would

save 4 percent on the total package.

Just a few more. If you were to remove the separate prescription drug deductible, you would increase the cost of the plan by one percent. And finally, as I mentioned earlier, the plan does not now cover dental for adults in its initial package. If you were to cover adult dental, you would raise the cost of the plan by 8 percent. On the other hand, if you were to remove dental entirely and take

away the dental for children, you would reduce the cost by 3 percent.

That concludes my summary, and I will be happy to answer

questions. Thank you.

[The prepared statement of Mr. Hustead may be found in the appendix.

Senator BINGAMAN. Thank you. I will have several questions, but

I think we should hear from the other witnesses first.

Before we do that, Senator Kassebaum, did you wish to make any opening statement?

#### OPENING STATEMENT OF SENATOR KASSEBAUM

Senator Kassebaum. Thank you, Senator Bingaman.

I think this is an important hearings. I think two important questions for us to answer are how the benefit package is shaped. and whether it should be a basic benefit package.

So I thank you for having this hearing. Senator BINGAMAN. Thank you, Senator Kassebaum.

Let us continue and hear from Ms. Jordan. Please proceed.

Ms. JORDAN. Good morning, and thank you for asking me to come and testify. I welcome this opportunity.

Our health plans at Southern California Edison cover 55,000 covered lives, that is, active employees, retirees, and their dependents. We currently offer a choice between six HMOs and a company-administered managed indemnity plan with a PPO option. We also provide a vision plan, two managed mental health plans, and a dental plan.

Comprehensive coverage should really be an essential element in any national health care reform package. Our advocacy of comprehensive benefits is really based on our successful experience in

operating a health benefits program.

I want to note that our beliefs are shared, as has been mentioned by the previous witness, by many other large corporations and that the Washington Business Group on Health and the National Leadership Coalition, both of which organizations have a number of major corporations that offer similar comprehensive benefits as our own.

Our approach is to select a network of high-quality providers, to structure our financial incentives for those providers, to provide care efficiently, and to encourage our enrollees to use those providers. In that context, we believe it is more cost-effective to offer a full range of treatments, providers and settings, and then let the providers decide on what the appropriate care should be.

We do not believe in controlling cost by limiting payment for specific treatments, and we believe that our strategy actually costs by

providing care more efficiently.

There are several reasons why we think comprehensive benefits produce better care for the patient and our employees and our retirees and their dependents.

First, we believe the physicians and patients can make better judgments about appropriate treatment at the point of service than

benefit specialists in the abstract.

Second, we believe that comprehensive benefits are really essential to encourage prevention and early diagnosis and treatment, and we continue in our program to emphasize health promotion and preventive care as critical elements in quality care and in

managing our costs over the long-term.

Third, comprehensive benefits permit and encourage continuity of treatment and the selection of the most effective appropriate care. Patients can be provided the appropriate tests, the appropriate professional care, the appropriate treatment settings, the appropriate medical equipment, and/or supportive services-all without the need to interrupt care, be moved to a different setting, or to avoid a treatment due to a limitation because a service is not covered.

And in the context of the capitated health plans with at-risk providers and primary care "gatekeepers," comprehensive benefits are really essential to the unrestricted ability of physicians to choose

the right kind of care for their patients.

Putting limitations on specific treatments encourages providers to game the system by recoding diagnoses or modifying treatment plans to ensure reimbursement; and at a minimum, they bias treatment decisions, creating incentives to use uncovered treatments

whether or not they are appropriate or cost-effective.

Now, we have particular problems with limitations posed by offering only catastrophic coverage. Although catastrophic plans have been proposed as a way to provide lower-cost plans, we believe they may actually raise health care costs eventually. That is because they discourage preventive care and deter individuals from seeking

care until late in the progression of illness.

Catastrophic plans based on high deductibles reduce premiums, yes, for the young and the healthy and those with lower health risk, primarily by reducing premium cost. However, I would like to point out that at the same time, when those same individuals become ill, particularly those who develop chronic conditions, they pay significantly more in health expenses under a catastrophic plan.

While the added out-of-pocket payments might encourage some individuals to reduce discretionary care, most individuals would simply be forced to pay more for necessary care. Patients rarely have much ability to alter their treatments to save money, and patients rarely have the knowledge or the inclination to second-guess physician recommendations. Thus, their ability to influence the cost of care is really marginal at best when they need it.

We believe instead that it is important to provide adequate coverage for clinical preventive services in order to lower the financial barriers to health education and counseling, immunization, primary care, including early diagnosis and treatment-all aspects of Edison's health plans, and that we believe contribute to a lowering of health risks and long-term health costs in our corporate plans.

Finally, a single Federal benefit standard is really essential to ensure the provision of equitable and continuous benefits for our employees without regard to their State of residence or work. We rely right now upon ERISA to provide us a structure under which we can operate a single plan. A uniform standard benefit is essential to ensure continuous coverage when individuals move across States lines.

Therefore, we support a Federal standard because it affords us protection from varying State standards if the ERISA coverage is limited.

In summary, I really cannot stress enough that employers and purchasers of care like Southern California Edison have really learned over the long run that comprehensive health benefits are necessary to ensure that patients receive cost-effective care, in the most appropriate setting, and that there is a continuity in treatment, and that treatment decisions are not dictated or influenced by coverage rules.

Thank you.

Senator BINGAMAN. Thank you very much.

[The prepared statement of Ms. Jordan may be found in the appendix.]

Senator BINGAMAN. Dr. Straub?

Dr. STRAUB. On behalf of The Jackson Hole Group, I would like to thank you for this opportunity to present some of our views on

the construction of a benefit plan.

As you know, the design of a benefit plan will in large measure determine the cost of a national health program. The benefit plan in effect defines the product of one of the largest industries in this country, and consequently will be the primary determinant of the expenditures or costs of that industry.

While we, too, believe that providing a single uniform effective health benefit plan should be the ultimate goal of any national health plan, we strongly suspect that providing a single comprehensive benefit plan at the outset will be necessarily very costly

and potentially delay access to those most in need.

Under an employer or individual mandate, the cost of providing a single mandated comprehensive benefit plan could be prohibitive for small employers and individuals alike.

There is also the danger of locking in any single comprehensive benefit plan and, as you well know, adding benefits is always easi-

er than taking them away.

So what alternatives are there? Assuming providing a single comprehensive plan initially to all Americans is not feasible fiscally, one could begin with a single comprehensive benefit plan that has been suggested and gradually phase in access to coverage as financing permitted.

Alternatively, one could begin with a single, less costly, perhaps catastrophic plan, with early access to coverage for everybody, and then add benefits as financing permitted. While fiscally attractive,

this alternative really offers less than many already have.

And then a third alternative, which we have come about gradually to embrace, is that one could initially offer both a less costly or basic plan with high cost-sharing for individuals, and a more costly standard plan with lower cost-sharing for individuals. We suggest that this approach would more closely balance need and affordability, while facilitating early universal coverage for everybody.

In other words, rather than phasing in access to coverage, we

would basically phase in equality of coverage.

Now, the principal disadvantage to this approach, of course, is that you would temporarily—and I would like to underline "tempo-

rarily"—create a two-tier system for a period. The principal advantage, we think, is that it would greatly facilitate access to coverage

for all Americans at a very early period.

Difficult trade-offs. The goal would clearly remain to arrive at a single uniform comprehensive benefit plan in a period of, say, 5 to 7 years, once more experience is gained with the costs of each plan and once reform has produced increased efficiency in our delivery system. We feel that our delivery system, which has largely been ignored, at least I feel, in much of the debate, which has focused on benefit plans and financing, unless there is fundamental reform of the delivery system to become more efficient, if you superimpose a comprehensive benefit plan on an inefficient delivery system to begin with, we feel it is a prescription for disaster in terms of cost.

So time, especially under a managed competition proposal where market forces would bring more efficiency within the system, then you could gradually phase up to a more comprehensive plan and

do it in a more cost-effective manner.

I should point out that under this approach, we would require all accountable health plans to offer both a basic and a standard plan, to minimize the potential risk selection problems and also the problems that were alluded to against going across State lines and so on

We would set a tax cap at the cost of the standard plan. This would encourage employers and individuals alike to buy up, if they

went into a basic plan, to buy up to the richer standard plan.

The proposal that I have mentioned is also, as an aside, compatible with the notion of medical savings accounts. For example, if the tax cap were set at the level of the standard plan which is more costly, and an individual selected a basic plan, the difference between those two might be available for investment in medical savings accounts.

I have attached model basic and standard plans for your consideration. I do not want to go over those in any detail. They do differ primarily in the level of cost-sharing. But I think it is very important to note that both of these plans are identical in their coverage of preventive services, and preventive services are covered at the

100 percent level.

Finally, the basic plan is approximately 25 percent less costly than the standard plan, and it is this difference in cost that we feel

would facilitate early universal coverage for all Americans.

Thank you.

[The prepared statement of Dr. Straub may be found in the appendix.]

Senator BINGAMAN. Thank you very much.

First, Mr. Hustead, going back to your testimony, you make a point, as I understand what you are saying, that adding a particular benefit may add to the cost of the plan, whereas deleting that benefit may not decrease the cost as much as adding to it. Could you explain that a little more?

Mr. HUSTEAD. Well, it depends on the benefit. We present a table that shows the breakdown of the benefit, say, between hospital, surgical, mental illness, and other. If you were just to take a whole category of benefit, like mental illness, and cut it out, or cut it way back, many of the savings that you would apparently achieve would

disappear because doctors and hospitals would find ways of calling mental illness other types of illness. So there is a lot of trans-

ference when you cut back particular benefits.

The other point, I believe, was that if you were to tell the individuals that for all benefits, if you are now paying, say, \$200 as a deductible before the plan picks up any coverage, and now you want to increase that to \$300, you will get two savings—first, the individual will pay more of the bills, and second, the individual will use less treatment because he will know that he has to pay an additional \$100.

So it is very much a question of how you design the additions and how you design the cutbacks. Some achieve what you want on the surface, but others, if they are mixed up with the rest of the

package, will simply shift the type of care to another type.

Senator BINGAMAN. On page 5, you list the amount of decrease in cost that would result from different changes. As I understand your chart there, you are saying that by going from a \$200 deductible to a \$300 deductible, you would save one percent.

Mr. HUSTEAD. Yes.

Senator BINGAMAN. That seems like a much smaller saving than I would have anticipated. Is that part of what you just explained?

Mr. HUSTEAD. Well, \$200 to \$300 sounds like a lot of money, but if you think in terms of, say, a \$10,000 hospital bill, and you are asking an individual in the first case to pay \$200 if the plan, say, were to pay the rest, the plan is then going to pay \$9,800. So now, if you say to the individual I want you to pay \$300 instead, the individual is going to pay 50 percent more, but the plan is only going to save one-tenth of one percent. Their total bill is going from \$9,800 down to \$9,700.

So when you look at what the individual has to pay out-of-pocket, their increase is going up substantially, but when you look at the share of the total bill that that takes care of, it is a very small pro-

portion. So changing the deductible does not do much.

Senator BINGAMAN. The one thing that does do much, according to this chart, is increasing the coinsurance requirement on individuals.

Mr. HUSTEAD, Yes.

Senator BINGAMAN. You suggest here that going from the President's proposed 80 percent down to 75 percent that would be paid by the employer would decrease the cost 6 percent of the overall plan.

Mr. HUSTEAD. Correct, yes.

Senator BINGAMAN. So presumably, if you went down to 50 percent—I think one of the suggestions that one of the witnesses is making is that you have a 50 percent coinsurance requirement—if you did that, you would save substantially more. Have you done that calculation?

Mr. HUSTEAD. Well, it would be tempting to take six times the 6 percent and say that. Two things occur. If you are literally going down to 50 percent and making the individual pay 50 percent of everything, then your savings will be very high because individuals will not be able to afford or use care very much.

But if you have a limit, such as \$1,000 or \$1,500, and you say you are going to pay 50 percent, but we are still going to limit your

out-of-pocket expenses to \$1,000, then the savings are diminished

So you have to look at the package as a total to see how much the savings would be. We can calculate those, but I could not esti-

mate it just based on the 6 percent number.

Senator BINGAMAN. Have you done any calculations or review of Dr. Straub's proposal to have a basic plan versus a standard plan and the cost savings that would be achieved by doing that?

Mr. HUSTEAD. Not that particular plan, no.

Senator BINGAMAN. Ms. Jordan, in your testimony, you talk about cost-sharing as something that you feel is very important as a way to achieve savings. Are you talking about essentially the 80 percent/20 percent distinction that the President has, or something different?

Ms. JORDAN. I am talking about that, and I am also talking about copayments. My comment was directed to indemnity plans and managed indemnity plans; I want to make that distinction, too. I think there is really less need for the levels of cost-sharing if you are in a truly managed care plan, like an HMO. Because care is being managed, you do not need to have the same kind of costsharing features as you need to have in the straight indemnity

Senator BINGAMAN. Dr. Straub, you obviously have a basic difference with Ms. Jordan's testimony. She indicates, as I understand it, that providing comprehensive benefits actually saves money in the long run, and that certainly does not seem to be what is re-

flected in your testimony.

Dr. STRAUB. I do not disagree with her at all. I think that in her experience, they have been able to develop very efficient networks of physicians and hospitals that can provide care very effectively and efficiently to their employees. And when you have that, you can really develop more of a comprehensive benefit plan character-

istics of HMOs.

But if you take an HMO-type package, in my view, and turn it loose in a relatively undisciplined provider community—and remember, still about half of our citizens are in indemnity-type plans where there is not the kind of managed care we would like to find—it could be very costly indeed, and that is why I would think that giving us 5 to 7 years to see more people move into managed care plans and see more discipline on the provider side, then it would make a lot more sense to me to provide a comprehensive plan for everybody at that time. I just have concerns about having a comprehensive plan for everybody in a very undisciplined delivery system for the plan.

Senator BINGAMAN. So your basic concern about this is that we would be going to a comprehensive plan while we still had most

providers on an indemnity basis—or many of them.

Dr. STRAUB. Well, they are not accustomed to managed care, and managed care does some interesting things. It makes doctors make resource utilization decisions much more effectively and efficiently than they do in an indemnity basis.

Senator BINGAMAN. So as we move toward less indemnity care, then you think a comprehensive plan makes sense and can be af-

forded.

Dr. STRAUB. Yes. I think that once you get 75 percent or so level of managed care, HMOs and PPOs, for example, that it would make a lot of sense then, and that is what we would favor in fact. We are not prescribing a prescription for just catastrophic insurance for everybody initially. We would like to see a blend and move to an HMO-type comprehensive plan, but not until the delivery system is really efficient enough to deliver it.

Senator BINGAMAN. Ms. Jordan, did you have any comment on

that? Is that in sync with your thinking, or not?

Ms. JORDAN. Well, actually, it is in sync with our comments in that, again, the issue about the cost-sharing is really in an indemnity environment, and if you do not have people in managed care, I would agree that there is no incentive—well, there is less incentive; let me put it that way—for physicians to manage care in a cost-effective way.

I do not know now what the coverage is with managed care. My suspicion is that there are probably more managed care features, I think, in a lot of areas in the country than there have been in the past—not necessarily HMOs, but certainly utilization review, case management, and some other features like that—that would argue for us really looking at a comprehensive benefit package.

I do have one reaction to the issue of two-tiered. We might want to suggest that in fact those who would need a lower-cost plan may be the ones who need the more comprehensive care. I cannot get away from that. And maybe what we need to do is require that they be in managed care programs versus trying to have this two-tiered system of a less comprehensive package for them.

In fact, my understanding is that many Medicaid programs have moved their populations to managed care programs just for that reason, because they understand that they need comprehensive benefits and that the way to do that and contain costs is to put

them in managed care.

Senator BINGAMAN. Do you have a comment on that, Dr. Straub? Dr. STRAUB. Yes, I would like to respond to that, please. What we are trying to do here, I think, becomes a little difficult when you try to superimpose a national program or a national benefit plan on the wide variability in delivery systems that exist around the country. Now, you can go to Minneapolis or southern California, and the penetration of HMOs and managed care may be as high as 80 percent there. In other parts of the country, it may be as low as 10 percent. I spent a lot of time in Pittsburgh, where it is 5 or 10 percent.

Senator Kassebaum. Like New Mexico and Kansas.

Dr. STRAUB. Or like New Mexico and Kansas. So it is very hard to superimpose something like this on a nationwide basis given the variability in the level of managed care throughout the country.

Senator BINGAMAN. Let me just indicate I have just gotten a note that Senator Dodd is managing an amendment on the floor, and that is why he is not here at the present time.

Senator Kassebaum?

Senator Kassebaum. Thank you, Mr. Chairman.

Well, I think when we talk about managed care we need to consider a State that has a scattered and large rural population. Citizens in rural States really do not understand how you deal with

managed competition or managed care. So this is where it is difficult to construct a "one-size-fits-all approach."

I guess all of you believe there should be a mandated basic pack-

age of benefits.

Ms. JORDAN. Yes, yes, absolutely. Dr. STRAUB. Yes.

Mr. HUSTEAD. I am appearing here as an actuary, providing factual information.

Ms. JORDAN. Well, I am appearing here with an opinion, and I

say yes. [Laughter.]

Senator Kassebaum. Well, I have always made the argument that one of the reasons that the basic basket was important was because we did need to talk about apples and apples, not apples and oranges. So we have to work off a common script. How we construct a basic benefit, I find difficult to understand, and I was very interested in all of your testimony.

Maybe I misunderstood, Ms. Jordan, does Southern California

Edison offer different plans?

Ms. JORDAN. Yes.

Senator Kassebaum. Do you require that everybody take one plan, and then they can purchase alternatives as well?

Ms. JORDAN. No. They must take basic coverage.

Senator Kassebaum. Everybody must take the same basic coverage, but then they can purchase other types of coverage beyond that basic coverage?

Ms. JORDAN. No. We have standard benefits across those plans, and they have a choice. They have an HMO choice, they have a

basic PPO choice.

Senator Kassebaum. I see, I see. But it covers the same things;

it is just how they wish to go into it.

Ms. JORDAN. The same list of services; right, exactly. And there are some differences in some of the copayment levels and the deductibles, so they have that choice. But then in addition, we have some backup reimbursement accounts, as he has mentioned, that allow people to offset, for example, their copayments by a reimbursement account that has \$500 per employee in it.

Senator Kassebaum. I was interested, Dr. Straub, when you were talking about getting to a comprehensive package as we can 1) afford it and 2) understand how best to get there. Is that cor-

rect?

Dr. STRAUB. That is correct.

Senator Kassebaum. Now, the President's plan has 18 different categories, I think, that he has delineated for coverage, and the most extensive is the preventive care. I think the estimates for cost, on and beyond the so-called Fortune 500, which some have said the President's plan would be in the benefit package, lies in

the preventive care area.

One of my concerns is how, really, either the administration or Congress can determine what should go into a benefit package. The pressure becomes intense, of course, to include everything. And someone has to determine what will be covered. The preventive care is extensive in its delineation in the President's plan. By comparison, Southern California Edison's package is determined by the insurer, I assume?

Ms. JORDAN. No. We define what we want them to give us a bid on, our standard package of benefits. We make those decisions, and

then we ask them for the bids on that.

Now, obviously, we do not do that in a vacuum. We have some sense of what is going on in the health care field and have some sense of what is efficacious and cost-effective. So we know what is going on, generally, in the health care industry in defining what that benefit package ought to be.

Senator Kassebaum. Dr. Straub, who do you think should define

the benefit package, and how should it be put together?

Dr. STRAUB. Well, I would like to see it, frankly, out of the political process. I would be much in favor of a national plan that is seamless across the country. The notion of a national health board or perhaps a department of HHS or somebody at the national level, but as much as possible, please keep it out of the political process.

Senator Kassebaum. Could it be an independent group, almost like the Federal Reserve—I hesitate to say that—or a Base Closing Commission type of concept, where you remove development of the benefit from the political process and this approach Congress would still have to vote, like in the Base Closing plan, possibly up or down.

Dr. STRAUB. Yes, sure.

Senator KASSEBAUM. Because of cost concerns I must say I think there is much merit to starting in a more limited way and adding to a basic package. Once you start with a very comprehensive package, as you pointed out, you cannot take it away. It is much easier to put in benefits than to take them out. There are a number of people who are very leery, of course, about having Congress design a set national benefit package. Do you give up your choices and so forth in designing that?

Dr. STRAUB. Are you talking about the choices, perhaps, of pro-

viders or individuals to influence it?

Senator Kassebaum. Well, everybody-individuals and providers

and insurers are going to have, of course, strong feelings.

Dr. STRAUB. Well, we would hope that any national body, be it a Federal Base Closing Commission or anything else, would get the input of everybody into the system. But I think it is the wide variability, with multiple insurers and multiple plans, that has made it absolutely impossible to understand what is going on in our system today, to measure performance of one plan versus another, etc. It makes it extremely difficult.

Senator Kassebaum. So if you start with a very basic package, and let everybody determine how they are going to purchase it—in small groups or through cooperatives—is there a need for a Federal legislative structure, like a health alliance. You would be ex-

empt I assume.

Ms. JORDAN. You mean exempt in terms of the alliance.

Senator Kassebaum. From participating in the health alliance.

Ms. Jordan. Yes, but I would like to point out that we have an interest in a standard benefit package for a couple of other reasons. In the first place, with this wide variability of benefit packages, you know, we pick up the care of our spouses and dependents who have less rich benefits or no benefits with their own employers. So we get that cost-shift to Edison, as well as the fact that we get the

cost-shift when people who have less comprehensive benefits and need care go into the hospital, get uncompensated care, and then our costs go up as a result of the people we contract with. So we have great interest in that. That is the first issue. And I think it really is important that we have some kind of standard package.

On Dr. Straub's point about where it sits in your question, I think it is difficult personally to legislate the definition of a package, because I think the issue that I have is that we know from benefit design that as treatments come into being that are considered to be more efficacious and not experimental, you have to deal with changing your benefits package to accommodate that, and there are all kinds of interpretations. And to do that by coming here every year is really going to be a struggle, and I think I am just being very practical about it.

Senator Kassebaum. For everyone.

Ms. JORDAN. Yes.

Senator KASSEBAUM. Mr. Hustead, I would like to ask you a question as an actuary. One of the aspects of care that has been addressed, and not of us have gotten very specific, is long-term care, because actuarially, it is difficult to project what that cost will be. I happen to believe it is important for us to discuss it. We are all living longer; demographics are changing significantly, but the cost could be significant for us to try to find a way to provide long-term coverage.

Have you done any projections on this, that if it would be part of the benefit package, that young people would be required to have it—that is, it would be a basic benefit—so that they are taking coverage on it now? Have you done any sort of actuarial figures on what the costs might be and how we can really handle long-term

care?

Mr. HUSTEAD. It depends. As you say, if you can fund it from a young age, it can be done quite economically. In fact, there are policies available that are very reasonable that do that. But you have the problem, if you put it in place today, many people will be covered who never funded it, and it is going to be quite expensive.

I think the bill starts with the assumption of the use as it is in the private sector of much of this care, that as long as it is a substitute for hospitalization or other care that would cost you more or perhaps the same amount, then that clearly should be done, and that can be absorbed. But to say today we are going to give everybody long-term care tomorrow is very expensive.

Senator KASSEBAUM. Right.

Mr. Hustead. Let me say one word on your earlier issue on the need for a standard package. One reason why it has been in the original Jackson Hole proposal and is now incorporated in the bill, the standard package, is that it is so confusing to choose. And you yourself and others have just gone through the open season of Federal employees' health benefits. Those plans, believe it or not, are quite similar, but if you pick them up and are trying to decide which one to choose, these little differences plan by plan totally confuse you. You ask, should I save \$20 a month and use this less expensive plan, what happens if I really get sick? And you cannot really focus on the cost issue.

So I think that is an important reason to make any type of these managed competition proposals work is to get the definitions the

same so that the individual can focus on cost.

Senator Kassebaum. Ms. Jordan, you mentioned cost-shifting, and I noticed you shaking your head in agreement, Dr. Straub. Isn't it true that approximately 30 percent of a premium is due to cost-shifting.

Mr. HUSTEAD. I think you are referring to the fact that with

Medicare and Medicaid paying a lower cost-

Senator Kassebaum. Reimbursement—that a hospital, for instance, will shift over to insured persons whose premiums will be-

come higher to help make up for those costs.

Mr. HUSTEAD. I have seen numbers that I think are defensible to suggest that shifting of 5 to 10 percent could be avoided. It is very difficult to measure what that shifting is, but I know in the administration's analysis of the proposal, they are assuming, I believe, that the premium paid by the private sector would be reduced by 10 percent because of the lower cost-shifting than there has been in the past.

Senator Kassebaum. Just one final question, although there are many I would like to ask. Do you think that Medicare and Medicaid should be rolled in so that there is the same structure, ulti-

mately?

Ms. JORDAN. Yes. Dr. STRAUB, Yes.

Senator Kassebaum. And Mr. Hustead, I guess you have not actuarially figured that out yet. [Laughter.]

Mr. HUSTEAD. Exactly.

Senator Kassebaum. Thank you very much. Senator Bingaman. Let me ask a couple more questions if I could before we let you go. Dr. Straub, your proposal on this basic plan versus standard plan, at first blush, I think that would indicate or the assumption would be that there is a different set of benefits provided with the two plans. There really is not a different set of benefits. You are saying the same set of benefits, but the copay and

the deductible should differ.

Dr. STRAUB. Correct. It became, as I tried to think through this, a very difficult issue. You wanted to construct something that would make it more affordable, and as I saw it, you only had two choices. You can limit benefits in the plan-in other words, the extend of coverage. For example, you might have to drop out some preventive services, or all of mental health, or all of nursing home. What services would you drop out to try to get a significant lowering of cost? And in talking with people in insurance companies and so on, they said the most-I would not say necessarily the best way, because that is a value judgment—but that the way they would proceed is to do it using cost-sharing to do it, shifting more costs to the individual. And as was pointed out, I have, frankly, a great deal of trouble with proceeding with that, because frequently, many of the people that you would want to see have the benefits could not afford them. In other words, if you said, well, a lot of the people who are working with small employers, and the small employers offer the more catastrophic plan, they really might have trouble meeting that.

Now, I think the poor could be handled through subsidy of their copayments as well, and of the cost-sharing from the Government. But it becomes this whole issue—if I were uncovered and working for a small employer, would I rather have nothing for a period of 5 or 6 years, or would I rather have something that allows me access to all of the services, because I cannot predict as an individual whether I am going to need a nursing home, mental health, or what the particular service is.

So I tried to make the services the same, but shifted more of the

cost to the individual. And that becomes a value judgment.

Senator BINGAMAN. The concern I have on this two-tier idea is that obviously, the cheaper plan, the one where a person has to pay more, the people who wind up with that are the poor people and the healthy people, because healthy people choose it because they figure they are not going to get sick anyway; they would rather not have any insurance, but if they have got to have something, they will sure take the cheap plan instead of the more expensive.

And the folks who take the so-called standard plan are the rich

people and the sick people. It seems to me-

Dr. STRAUB. I think if you look at corporate America, most of the people who would perhaps be above the cut-off for the health alliance would already be being offered a standard plan by their employers. So that what you are talking about is the potential of individuals going into the health alliances and many of the smaller employers. Then the option would be there—do you want the standard or do you want the basic?

And I would add the wealthy to those people who might choose

the catastrophic or basic plan. They can afford-

Senator BINGAMAN. If they are healthy enough, sure.

Dr. STRAUB. Well, not only if they are healthy. I mean, they can afford to go at risk more than the poor. So at the extremes, I think the wealthy and the poor could really elect to go into these plans, with the Government picking up the balance of the cost-sharing for the poor. And I think it becomes a question of whether you want to focus on middle America or you are focusing on the tails when you are designing, if you are trying to design one plan, and that

becomes a problem.

Senator BINGAMAN. Mr. Hustead suggested that if you take the benefits, and you increase the coinsurance, as I understand it, to 75, so that instead of the Government or the plan, the employer, paying 80 percent, the individual would pay 25, and the employer would pay 75, that saves you 6 percent. That is what his chart says. Wouldn't it make more sense to vary that and keep one plan, instead of having the two tiers, if you have got to go to 75 and save 6 percent, do that? Do you have any actuarial calculation as to how many people would take the basic plan versus the standard plan and whether or not that would save 6 percent?

Dr. STRAUB. No, and I think that is a critical question that, frankly, I would have liked to have done through The Jackson Hole Group, but we really did not have the resources. I think it requires a pretty sophisticated modelling system where you balance let us say 20 percent in basic and 80 percent in standard, and then the whole range, and you figure out what the cost to the Government and to employers and to individuals might be if you did that. But

that requires a pretty sophisticated model, I think—probably as sophisticated as trying to figure out what the cost of offering a single comprehensive plan in an undisciplined system is going to be.

Senator BINGAMAN. OK. Thank you.

Did you have other questions of this panel, Senator Kassebaum?

Senator Kassebaum. No, thank you.

Senator BINGAMAN. Then we will excuse you. Thank you all very much. We may follow up with other questions as we think of them.

Our second panel includes Cindy Mann, from the Massachusetts Law Reform Institute, who will speak to us about the need for affordable health insurance, particularly for low-income individuals; Gail Shearer of the Consumers Union will talk about a recent consumer survey and the importance of providing comprehensive benefits; and finally, Ronald Burd, of the Devereux Foundation, will discuss the need for mental health benefits.

Thank you all for being here. Cindy, why don't you go right

ahead?

STATEMENTS OF CINDY MANN, MASSACHUSETTS LAW REFORM INSTITUTE, BOSTON, MA; GAIL SHEARER, CONSUMERS UNION, WASHINGTON, DC; AND RONALD BURD, PRESIDENT, DEVEREUX FOUNDATION, DEVON, PA

Ms. Mann. Thank you. Thank you for the opportunity to present testimony to the committee on this important topic this morning.

As you stated, I work for Massachusetts Law Reform Institute, which is a poverty law center in Massachusetts, and we represent low-income people. I particularly work on health care. It is, therefore, to me and to my clients exciting that you are debating at this moment the extent to which the system of health care in this country can be overhauled in a systemic way. But I think some of the discussion this morning, as well as other matters that have come before this committee and others, leaves people with low incomes and people with disabilities, people with chronic illnesses, the most vulnerable of health care consumers, with really very grave concerns about what may be the outcome of debate.

It is certainly our view that reform will not be accomplished, in fact, it will not even be moved in the right direction, if what we are left with is a two-tier system which imposes substantial cost-sharing obligations on people with the least ability to afford those

obligations.

In my work, I see daily single mothers who are leaving their jobs because they cannot afford the employment-based insurance system that is offered to them; they cannot cover their children, and they have to leave their jobs. Even if insurance is offered, it is often offered at a price that they simply cannot afford. They will leave their jobs in some cases to establish or re-establish Medicaid eligibility to ensure that their children get health care.

I see homeless families that cannot even get to the doctor because they do not have the bus fare to get from the shelter to a clinic. When we are talking about imposing cost-sharing obligations, the scope of the gap between people's incomes and their basic needs has to be taken into account, and that gap us very severe

for many, many families.

I see people with AIDS, with the HIV virus, who are still working, who cannot afford their medications even with insurance coverage because of cost-sharing obligations and the extent of medications that they need.

Last week, I spoke to someone who was literally sobbing because she had a 50-cent copayment for a prescription drug, and she had no ability—she is disabled, on SSI—to come up with the 50 cents

that Medicaid imposed for her prescription drugs.

Health care reform will not mean anything to any of these people unless we address the question of affordability—and affordability

to some is apparently different than affordability to others.

In our view, the Health Security Act goes far to address the issue of affordability. There are many critical features in the bill that we think will take us in the right direction. It is a comprehensive benefit package. Therefore, people without the ability to buy supplemental wrap-around benefits are still protected with a reasonable package of benefits.

In addition, there is blended rate structure, there are subsidies for low-income people for premiums. We think improvements need to be made, particularly with respect to the cost-sharing subsidies, the copayments, and coinsurance, and we hope the committee will

consider those revisions.

But I want to as much as anything this morning urge you not to think about substantially reducing the benefit package, increasing cost-sharing obligations, and not providing the adequate subsidies that people—not just very low-income people, but moderately low-income people, people in that \$14,000, \$15,000, \$16,000 a year job with children to support, single moms—who cannot now afford their cost-sharing obligations and who will not under any kind of reform that similarly imposes those kinds of obligations.

Those kinds of proposals, I would submit, are not cost savers, they are not reasonable transition measures, and they will deny critical services to many people who I think you all want to make sure receive coverage, and they will inevitably increase utilization

of more expensive care.

When you look at health care reform, it is easy to focus on what will work for some people and not for others, and we talked earlier about what spectrum of folks we are concentrating on, but we cannot lose sight of the fact that there is an incredibly strong relationship between lack of insurance and poverty. In the United States, if you are under 65, you are five times more likely to be uninsured if your income is below 200 percent of the poverty line than if your income is above it. That relationship has to be addressed with a

great deal of seriousness.

Measures which will work for middle-income families in terms of addressing affordability tensions will not work for poor families. If you have a \$10 or a \$20 copayment for somebody at the poverty line, it is the same as a \$36 or a \$72 copayment for somebody who is at the Massachusetts median income. We would not think of imposing a \$72 copayment on a median income family to go visit the doctor. That is the same as doing a \$10 copayment for low-income family, only it is worse, because all too often, they do not even have

the \$10 to make that payment.

In Massachusetts just this week, the rate-setting commission came out with a study showing that in 1989 and 1990, \$473 million was spent on preventable hospitalizations, hospitalizations that basically flowed from people not getting the kind of adequate primary

preventive care that they needed.

If for no other reason than the cost reason, that study shows why we cannot impose unaffordable obligations on people. Massachusetts residents paid that \$473 million price tag. That did not go unpaid. But we paid it because we did not make the choice of providing a comprehensive benefit package to all people in the State at a price that they could afford. So there was an enormous utilization of inpatient services that otherwise should have been prevented, and a cost-shifting to other payers in the State in very unproductive ways.

I will stop here, but finally, just to make one point. You have a lot of actuaries come before you, a lot of economists, a lot of tables. The bad news, I guess, is that I cannot present you with the perfect table to show you the impact of the kind of cost-sharing obligations and inadequate subsidies and what that will do to so many families and so many individuals who are our most vulnerable health con-

sumers.

But the good news is that I can leave you with what I think is an undebatable truth—and there are not that many around here—and that is that if you do not have any money, you cannot afford to pay much, if anything, for your health care. And we should not be lulled into thinking we are moving toward reform if we are doing nothing other than offering coverage at a price tag that people just simply cannot afford to pay.

Thank you.

Senator BINGAMAN. Thank you very much.

[The prepared statement of Ms. Mann may be found in the appendix.]

Senator BINGAMAN. Gail, please go ahead.

Ms. SHEARER. Thank you, Senator.

Thank you for inviting Consumers Union to testify today on the issue of comprehensive benefits and national health reform legislation. Before addressing consumers' urgent need for comprehensive health benefits that are explicitly defined in the legislation, I would like to briefly address the question of whether there is indeed a health care crisis. And I know that members of this committee need no convince that there is a health care crisis.

When Consumer Reports analyzed the legislative options under consideration in 1975, two of the five bills in our article bore this committee chairman's name, Senator Kennedy's. The naysayers, members of a modern-day "flat earth society," may be able to convince themselves that there is no health care risk, but rest assured,

they cannot fool the American consumer.

Some symptoms of the crisis: 8.3 million children in this country are uninsured, leaving them without preventive care, acute care, and rehabilitative care when they need it. Millions of our country's seniors are forced to choose between buying food and buying the medicine they need, since Medicare does not cover prescription drugs. Thirty-five to 40 million Americans are uninsured, greatly reducing their access to health care and sending them too often to

the emergency room for urgent care that could have been prevented had they gotten earlier treatment and medicine.

There is indeed a health care crisis. Enactment of health reform legislation this year that will provide guaranteed comprehensive

benefits to everyone is essential.

In the remainder of my statement, I plan to make the case for explicitly-defined comprehensive health care benefits. First, consumers want comprehensive health care benefits. When Consumers Union commissioned a Gallup survey in April 1993, we received a very clear message from consumers—they want comprehensive health care benefits. Virtually all—close to 90 percent in each case—of those polled favor universal access to a comprehensive health care plan that includes doctor care, hospitalization, prescription drugs, well-child visits and immunizations, nursing home care, long-term care at home, mental health treatment, dental care, prenatal care, and vision care.

When asked about the possibility of phasing in health care benefits, at least 75 percent of those surveyed wanted each of these benefits phased in within 4 years, with a strong preference for phasing in doctor care, hospitalization, well-child and immunizations, pre-

natal care and prescription drugs within 2 years.

And I might note I was very interested to hear Senator Kassebaum's comments about long-term care. The survey was very clear. Consumers of all ages strongly support including both a home care benefit and nursing home benefits in a reformed health care system. And one thing that our research at Consumers Union has demonstrated very clearly is that the private market cannot solve the Nation's long-term care crisis. People who cannot afford a longterm care policy, or people who do not qualify for a long-term care

policy will always be left out.

The second main point is that consumers need comprehensive health care benefits. The private market is not up to the job. In order to achieve true health security, benefits must be comprehensive. Each family has its own unique health profile and its own set of health care needs. Whether your health need be for a cancer operation, physical therapy to improve the quality of life of a child with cerebral palsy, a measles shot and other immunizations to prevent chronic illness in the future, home care for a grandmother with Alzheimer's disease, insulin for diabetes, or medicine to control high blood pressure, every family needs health care of some kind.

The private insurance market is not designed to come to your assistance when you need help. The private market is designed to maximize profits for insurance companies. The cliche that you cannot buy fire insurance when the barn is already burning applies to health insurance. Once a family needs long-term care, insulin for diabetes, chemotherapy to treat cancer, insurance companies prefer not to take your call. It is clear that what is best for insurance companies is not what is best for sick consumers.

The third point is that Congress should not leave the design of the benefits package to a benefits commission. There are only two bills before the Congress—the Wellstone-McDermott single-payer bill; and the administration's Health Security Act—that spell out a comprehensive benefits package. Other bills delegate decisions about benefits to outside commissions after enactment of the bill.

Passing health reform with an unspecified benefits package is like an arranged marriage—you simply do not know what you are getting. Consumers Union would never recommend a consumer buy an insurance policy without reading the fine print that could limit coverage. Passing the buck to a commission does not even give the American taxpayer an opportunity to read the fine print, and threatens to reduce health benefits that many people have worked so hard to attain. It is crucial that Congress spell out the benefits in the bill. The benefit design is simply too important for Congress to pass the buck.

Fourth, comprehensive benefits will be meaningless if they are combined with a catastrophic insurance policy. The promise of comprehensive benefits will be hollow if, as in the Chafee, Lott and Nickles bills, consumers can buy a catastrophic insurance policy with a \$2,000 or \$3,000 deductible and be considered insured. A \$3,000 deductible does not deliver preventive care to children, \$2,500 worth of insulin to a diabetic, or many other pressing health

care needs.

Many low and middle-income families will not get access to comprehensive health care. Instead, they will end up with an unfunded medical savings account and a catastrophic policy with a high deductible. Financial barriers to health care will continue for these

families.

Fifth, if guaranteed benefits are not comprehensive, there will be a burgeoning supplemental market. If Congress, or even an outside benefits commission, designs a barebones benefit package, the market response is both predictable and alarming. Insurance companies that are excluded from participating in health alliances—probably because they are less efficient and provide less value—will rush to find their market niche-the supplemental market. All of the problems that have plagued the health care market will be shifted to the supplemental market—the very type of problems that plagued the Medigap market for 25 years before Congress, under the leadership of Senator Durenberger, enacted very successful reforms in 1990. There will be pre-existing condition exclusions, denied coverage, frivolous variations in policies, and an inability to make apples-to-apples comparisons. The bottom line will be a multitiered health care system, with the lucky getting barebones coverage plus supplemental coverage, and the unlucky relegated to barebones only protection.

Sixth, if coverage is voluntary, the comprehensive standard benefits will not guarantee security. A voluntary plan simply does not offer the security that consumers want. Without mandating an employer contribution, there will never be a level playing field be-

tween employers.

A comprehensive benefits package is meaningless to you if you are one of the 25 million or 39 million people left without any insurance at all, as would be that many under some of the voluntary

bills under consideration.

Many supporters of a voluntary approach proclaim the fact that their bill restricts pre-existing condition exclusions. But in fact, pre-existing condition restrictions will continue to exist under reform that is voluntary. As long as there are pre-existing condition periods of 6 months in the voluntary bill, children with diabetes, children in need of therapy, pregnant women, and millions of others who get sick will have their own horror stories to tell about the gaps in the system. And yet without these pre-existing condition restrictions, insurers will be unable to keep consumers from buying health insurance only when they get sick. A voluntary reform approach simply cannot close the health care gaps and end the suffering of children and adults who are left out of the system.

In sum, the popular slogan of the week regarding crime control, "Three strikes and you are out," can be applied to health care reform. Strike one: Make participation and employer contribution voluntary. Strike two: Pass the buck on defining benefits to an outside commission. Strike three: Encourage catastrophic policies with a

\$3,000 deductible.

Any one of these crucial mistakes will totally undermine health care reform and result in gaps in coverage and continuing suffering, lack of needed health care, and financial barriers to care. We urge you to avoid these mistakes and assure that consumers' dream for universal, comprehensive health care benefits will become a reality.

Thank you, Senator.

Senator BINGAMAN. Thank you very much.

[The prepared statement of Ms. Shearer may be found in the appendix.]

Senator BINGAMAN. Mr. Burd, please go right ahead.

Mr. BURD. Thank you, Mr. Chairman, and thank you for this op-

portunity to be heard.

In the formal statement that I am inserting with your permission in the record, we have set forth our specific expertise and recommendations. But in the brief time allotted to me today, I want to speak on behalf of the estimated one in every four American families who have experienced, or will in their lifetimes experience, the special pain and costs that arise when a member of the family suffers a specific, diagnosable mental disorder.

One in every four families. Those families are looking to this committee for assurance. Those families need your assurance that the treatment of mental disorders under this legislation will be accorded the same respect and recognition as the treatment of any other disorder—no discrimination, no delay, no deferral, no dilu-

tion.

Those families need your assurance that a comprehensive, flexible mental health benefit will be included in the standard benefit package—at the start, not 5 or 7 or 10 years later, when the sick will be sicker, and the costs of curing and caring for them even greater; in full, not subject to arbitrary restrictions that would deny appropriate treatment to the treatable; and spelled out, not left to the whim of some future, politically unaccountable board that is like to focus, as such establishment groups so often focus, on the supposedly respectable and manageable areas of human ailment.

Those families need your assurance that you will weigh the very heavy, tangible cost to our Nation of short-changing mental health—more poverty, more homelessness, more welfare, more

crime, more prisons, more unemployable and unemployed, more suicides, more dysfunctional families, more taxes, and less productivity to pay for it all, against the very real but increasingly man-

ageable cost to our Nation of treating mental illness.

We at Devereux can tell you from over 80 years of experience that HCFA's estimated cost of \$800 per day for both inpatient and residential mental health treatment is just too high; that the increased use of medications like lithium and clozapine has made the old-fashioned assumption that most mental health patients will never lead independent lives unnecessarily gloomy; and that the contention of The Jackson Hole Group and others that in mental health, the techniques of case management are not yet sufficiently developed is simply uninformed.

Successful techniques are being pioneered by such companies as Honeywell, Digital, and Federal Express, as well as a number of State-administered Medicaid programs. Those techniques could surely be extended throughout the country during the 4 years now contemplated between the bill's enactment date and its effective

date

Finally, Mr. Chairman, those families need your assurance that Congress, amidst all the horse-trading, log-rolling and cost-cutting needed to pass a health bill, will not overlook the most overlooked, underrepresented, powerless, helpless group of patients in our soci-

ety today-mentally ill children.

Who among us who has not personally borne the burden the parents of such children bear can blithely talk about limiting the care that those children can receive? No other childhood illness—not one—causes greater suffering and disruption to families, schools, communities, and above all, the children themselves—the maligned, mistreated, sometimes destructive, but nevertheless innocent, suffering kids, who have no chance for that treatment. No other childhood illness if left untreated is more potentially debilitating for the rest of that child's entire life, and no other childhood illness if left untreated is more expensive for that child's family, community, State and Nation.

A fully funded mental health benefit for children would bring enormous long-term benefits to this country, to our productivity and social stability, to our economic and fiscal well-being, and to

our pride and dignity as a caring people.

Mr. Chairman, please do not place harsh and arbitrary limits on mental health services for children. To do so would be fiscally unwise, medically unjustified, and socially unsound. Above all, it

would be wrong.

Mr. Chairman, I made reference to Devereux' experience with the costs of inpatient and residential care for children. We have just completed a 2-year study involving over 800 patients, children and adolescents, who received services in five Devereux programs in four States, that show that the cost of care is dramatically lower than the \$800 figure I referenced. I would like to submit that, with your permission.

Senator BINGAMAN. We will be glad to receive it. Thank you. [The prepared statement of Mr. Burd may be found in the appen-

dix.]

Senator BINGAMAN. Let me ask each of the witnesses to comment. I think the problem we have here is that obviously, to reform the system, we need to try to provide adequate health care that is affordable to those who need it, but at the same time try to reduce and eliminate to the extent possible the unnecessary utilization of the system.

I think that there is a lot of unnecessary utilization of our health care system today by people who have coverage. I think we have that mindset, that you go and see the doctor at the drop of a hat. And I know they are running advertisements in Canada now, saying you do not need to go and see the doctor each time you get a

runny nose; some things, you can do yourself.

How do we keep the personal responsibility part in this? I mean, if we cover everybody and have no copayment requirement or no coinsurance requirement for poor people, how do we avoid overutilization of the system?

Cindy, do you have any thoughts on that?

Ms. Mann. I think what you have to worry about more with low-income people is underutilization. I think that has actually been the pattern and the history, and where the costs have hit the system, and the preventable hospitalization study I think is just one example of patients who did not go to the doctor when perhaps they needed to and therefore ended up in the emergency room or otherwise using acute care facilities.

It is not to say that some cost-sharing and some financial obligation and responsibility being imposed on individuals is necessarily a bad thing; it just has to be done in a way that is sensitive to ability to pay. And what would appear to be nominal for one family and not a financial barrier will not in fact be nominal and not a

financial barrier for another family.

So what I am really trying to stress is a relative concept, that individual responsibility is not inherently a bad thing, but it really has to be very sensitive to ability to pay so it is not a barrier rather

than a mechanism for assuring appropriate care.

I think more important in terms of low-income communities is looking at the infrastructure of the health care delivery system. There need to be adequate primary care providers. There need to be systems in place, school health centers and better facilities within communities, so that care can be managed in ways that make sense given people's situations and their particular needs. And if we put a lot more attention into that, then I think we will see the kind of proper utilization that we all want to see out of reform.

Senator BINGAMAN. So a lot of the needs that you see for low-income individuals could be effectively dealt with by increasing the public health efforts that we fund. In my State, we have a lot of rural health clinics, for example, where there is essentially no cost to folks to come in and get basic are. I think the way they operate, they are supposed to charge on a sliding scale depending upon whether a person is able to pay. But people who do not have the wherewithal just go there and get their health care. So you are saying an expansion of those services as part of this health care reform.

Ms. Mann. As part of this health care. I certainly would not want to see us have one system for poor people and one system for

everybody else, and there are some areas, particularly rural areas, where I think there is just no system at all, no facility, no delivery system. So you do need to think very much about developing those special rural health centers, migrant health centers, that provide

that outreach to particularly vulnerable populations.

I think that in a State like Massachusetts, where there are a lot of health care delivery systems in place, for some, anyway, that we need to figure out how those mainstream systems can be more sensitized to the needs of inner city folks and people with different health care needs. But I think attention to that delivery system and infrastructure is a much more positive way to think about proper utilization mechanisms than presenting financial barriers.

Senator BINGAMAN. OK. Gail, did you have any thoughts on whether this is a potentially serious issue, this issue of potential overutilization of the system; is that something we ought to worry

about, or do you think it is not a problem?

Ms. Shearer. We think it is a problem, and it needs some attention. Last year, Consumer Reports Magazine estimated that we are now wasting approximately \$130 billion on unnecessary medical care. This is often because there is tremendous pressure on provid-

ers to over-treat.

The world seems to be divided in two sets of people—people who think that insurance is bad because it encourages people to get health care, and people who think that insurance is good because it removes financial barriers to care. The challenge for public policy is to set these deductibles at the right level, and what the Health Security Act does I think is appropriate in terms of having costsharing, subsidizing cost-sharing and copayments for the low-income. We believe that there needs to be additional cost-sharing of the copayments for low-income individuals, and we agree with what Ms. Mann has said.

There are provisions in the Health Security Act that are going to help with this problem. First of all, there is a greatly expanded effort to improve on outcomes research. We need to understand better when treatment is appropriate, what treatment works under different circumstances. And then what we need to do is translate this research into treatment protocols that could be implemented on a uniform basis across health alliances or whatever the structure is under reform, and that way, the health alliance, the national health board, will be in a better position to monitor the ap-

propriateness of care and cut out care that is not necessary.

Senator BINGAMAN. As I understood a comment Ms. Jordan made in the prior panel, in reference to Dr. Straub's two-tier plan, I think the idea was that perhaps, instead of two tiers, you would go to a system where you would encourage people to go into a managed care system, and you might use the copay variable to provide that encouragement or that incentive, so that you would say if you are going to go into a managed care system, we will require less copay by the individual; if you want to stay in an indemnity system, we are going to require more, because the system as it functions will not prevent overuse.

Do you have any thoughts on that?

Ms. SHEARER. Yes, and this in fact is a provision of the Health Security Act. We have some concerns about it. One of the goals of

the Health Security Act is really to increase the choice that con-

sumers have and the type of health care that they receive.

There is no provision in the Health Security Act to restrict the premium differential for the managed care plans versus the traditional indemnity plans, and what this means is that we are concerned that low- to moderate-income consumers are going to be pushed into managed care, with relatively restrictions on their ability to choose doctors, possibly getting inferior care, depending on what kind of regulation of quality there is.

We are concerned about the prospects for a multitiered health system really being perpetuated unless there is some effort to modify the premium structure and to ensure that low-income and lowto middle-income consumers have the ability to go to a traditional

fee-for-service type of plan.

Senator BINGAMAN. OK. So you do not favor the idea of providing a financial incentive for people to go into managed health care; you

think that would be discriminatory against low-income?

Ms. Shearer. Yes. We would like to modify the premium structure so that the low-income people do not end up by economic ne-

cessity in a lower-quality plan.

Senator BINGAMAN. OK. Mr. Burd, let me ask you in the context of mental health, do you think there is a problem of overutilization of the system today, or do you think there might be under this plan as proposed, and if so, how do we deal with it?

Mr. BURD. I do not believe there is today. In fact, all the research suggests there is underutilization of the mental health system, for a number of reasons. Certainly the stigma associated with mental illness is still with us, and we find that diagnosable mental ill-

nesses oftentimes are not treated.

I would like us, though, to take a little different tack, a little different cast. In all the discussions around health care reform—and obviously, we have to make some tough choices; we cannot afford everything that everyone would like to have done—but preventive services make sense, and I think most people are advocating that we invest some money in preventive services. And again, the research shows that wellness programs and early intervention do make sense. I would contend that we need to think of mental health in that broad context. It is a preventive service. It is preventive in the adult population in helping people avoid other kinds of physical disabilities; if they are not taking care of themselves from a mental health standpoint, oftentimes physical illness comes into play, as well as lost productivity in the workplace.

So we need to think about it as a preventable service—but particularly with children. My strongest emphasis is in the area of providing adequate coverage for children, because we know that if children are not treated early, they are going to have a very, very tough road ahead, and the cost to society is going to be enormous. And it is not a question of overutilization. What we see with many children is that it is the wrong utilization. Many of the kids who come from broken families where they have seen a lot of abuse that has led to drug use, or that has led to a very, very sad State of affairs, find themselves in the juvenile justice system. That is a utilization cost to society as well, and we need to think about that.

So I would contend that we need to have more effort in prevention that is focused on mental health services for adults, but par-

ticularly for children.

Senator BINGAMAN. Let me just indicate a concern that I have had. In Albuquerque, the largest city in my State, there is a very competitive market among psychiatric hospitals to provide service, and they have ads on television all the time, it appears to me—whenever I am watching television, there are ads on that ask, Is your child talking back to you? is your child not taking instructions, or going into his or her room and closing the door? If so, call our psychiatric hospital, and come see us.

I have had concerns that in an effort to market these services, we may be catching up in the system a lot of kids who do not belong in psychiatric hospitals and do not really have psychiatric problems, and their parents cannot deal with them because they

are at that age where they are tough to deal with.

Mr. BURD. I have those very same concerns.

Senator BINGAMAN. How do we deal with that? That, to me, is overutilization of the system.

Mr. BURD. Yes.

Senator BINGAMAN. And as a taxpayer, I do not want to be paying to provide psychiatric services for every kid who talks back to his parents, but at the same time, I do not want my own child or children that I know caught up in the system if they should not be there.

Mr. BURD. And as a not-for-profit organization that has been around for 82 years, I am very concerned because some of those organizations have tarnished our reputation in the way that they have tried to market their services. There is overutilization in that area, and I think we need to respond in a couple of ways.

First of all, we need to have appropriate services. Oftentimes, that child who is talking back to his parent needs a simple intervention that could be done in the school setting, or some basic edu-

cational programs involving families and children together.

But I think in a larger context, we need to avoid overutilization by managed care and some utilization review and by investing much more in looking at outcomes. What is it that we are trying to do with children who have mental illness and can function in an open environment? We have to make sure that we have very strict admissions criteria that are being adhered to, that utilization reviews are being done, as well as outcome measurements, to determine whether we have been effective. I think that will sort itself out.

Fortunately, we are seeing dramatic reductions in some of those programs around the country that came into the marketplace mostly in the 1980's and the early 1990's, thinking that they could

make money very easily.

Senator BINGAMAN. Well, I would be interested—do you think the plan that the President has proposed has those safeguards in it, or do we need to look at that as something that we consider here in the committee?

Mr. BURD. The current plan has some limitations on inpatient and outpatient services. My concern is that, particularly for children, those limits are artificial, and I would suggest that we remove those, but then put in some features that could monitor appropriate admissions utilization and then outcome. So we do need some more work in that area, but it is doable.

Senator BINGAMAN. Thank you.

We have statements from Senator Dodd as well as Senator Thurmond that they wished to have introduced into the record and also some questions that Senator Kassebaum wanted to ask you, Mr. Burd, and I will submit those for the record; if you would be kind enough to respond to those, I am sure Senator Kassebaum would appreciate it.

[The prepared statements of Senators Dodd, Jeffords, and Thurmond follow:]

# PREPARED STATEMENT OF SENATOR DODD

I thank the Chair for convening today's hearing on the critical matter of the benefits package to be available after health care reform. This discussion should be at the heart of our debate over health care in this country. I say this because I think the basic benefit package will be a yardstick most Americans will use to evaluate their health care after reform. This issue cuts right to the question people have about reform, "what will this mean for me and my family?"

# CURRENT SYSTEM INADEQUATE

To answer that question, we should look first at what's available in the current system. Today, we have no standard benefits package. Health plans contain widely different benefits, different copayments, different deductibles and different provisions regarding limits on lifetime expenditures.

These disparities make thorough comparisons between plans exceedingly difficult, contribute to cost-shifting and often discourage preventive care. And because there is no fixed minimum benefit

package, benefits can arbitrarily change from year to year.

### BENEFITS CAN DISAPPEAR

Even benefits that are part of a plan may vanish if a patient bumps up against a lifetime limit. Patients may also find themselves unable to receive a benefit if it's needed to treat a "pre-existing condition." these faults conspire to make sure that benefits are often not there just at the moment they are needed the most.

In addition, traditional indemnity coverage typically fails to cover preventive care. These policies put all of their focus on people after they become sick without doing anything to keep them from becom-

ing sick in the first place.

#### TRUTH IN ADVERTISING

The President's health care reform bill would remedy these defects. And unlike other plans out there, it would spell out up-front what benefits would make up a basic package. The plan would live up to one of the basic dictates of truth in advertising principles: "what you see is what you get."

The President's plan spells out exactly what people could expect from reform: it does not leave fundamental decisions about basic benefits to some amorphous panel to-be-named later. I think it is imperative that the American people understand the shape of re-

form before we ask them to support it.

The President's plan would achieve this goal: it is open and frank with the American people about the basic benefit package that would serve as a minimum for everyone. Among other things, the President's plan would cover physician visits, hospitalization, prescription drugs, preventive care, and some mental health services.

# BASIS FOR DISCUSSION

In the months ahead, there will be a great deal of discussion about the details of this package and which services should be covered. This should prove to be a healthy discussion, and Congress will undoubtedly modify the President's proposed package somewhat. The more important point, however, is that the President's proposal provides an excellent foundation on which to conduct the discussion, and I look forward to beginning this process today.

# PREPARED STATEMENT OF SENATOR JEFFORDS

Mr. Chairman and Senator Kassebaum, thank you for holding this hearing on one of the most complicated issues facing this body in developing national health care reform—design of the guaranteed benefit package. Over the last two days this committee has heard witness after witness ask Congress to authorize a uniform national package that would be portable from job to job and across State lines.

We must accept this challenge. Many people think the benefits should be spelled out in the law as passed by Congress, and I understand the arguments for doing so. But I think we should take a hard look at delegating this responsibility with subsequent Congressional approval. This is the approach advocated by my colleagues, Senators Kassebaum and Chafee, and is the approach I took in my own proposal.

The more difficult issue we must grapple with is what appropriate level of benefit is comprehensive and affordable so that every American has access to health care. Personally, I believe very strongly that mental health is an essential and integral component

of health care.

I was astounded to recently learn that IBM actually saved \$100 million dollars, over a three year period, by offering an unlimited mental health benefit and instituting a managed care approach to treatment. Mr. Burd's testimony mirrors many of my own constituents who have argued persuasively that parity in mental health benefits produces not only direct savings but, also social cost savings that come from the reduction of juvenile crime and increased productivity in the work place. In addition, medical cost offsets or decreased medical utilization occurs when mental and substance abuse services are made available to patients who need them. Similarly, Ms. Jordan's testimony echoes many of my constituents arguments that preventative services in the form of screening and early detection, specifically in the area of breast cancer, will produce enormous savings in our health care system.

Determining the appropriate benefits package is an awesome responsibility. We must keep in mind that our objectives for health care reform are two fold: universal coverage and cost containment which produces real deficit reduction. I am confident that the testimony of todays witnesses will be extremely helpful in our deliberations.

# PREPARED STATEMENT OF SENATOR THURMOND

Mr. Chairman, it is a pleasure to be here today to receive testimony concerning the Guaranteed National Benefit Package included in the Health Security Act. I would like to join my col-

leagues in welcoming our witnesses.

As you know, the American Health Security Act of 1993 would entitle all Americans to a package of guaranteed national health benefits. This guaranteed benefits package includes mental health services, substance-abuse treatment, and some dental and clinical preventive services. The mandatory package includes not only major medical services, but also incorporates routine eye and ear examinations and even elective abortion services.

The Health Security Act would also require every health plan to provide this standardized package of health care benefits. This requirement will replace the consumer's ability to choose benefits. Moreover, as the government aggressively promotes managed care, the ability of doctors to treat patients according to their independent professional judgment will be severely circumscribed. These limitations will make it difficult for Americans to take advantage of new or specialized medical services.

The National Health Board will set national guidelines for determining which treatments can be provided or upgrade, which treatments are or are not "medically necessary", and even how often approved treatments or tests can be conducted. New benefits, including new treatments, medical procedures, or devices for the treatment, prevention or cure of disease will have to be approved by the National Health Board, or Congress, before they can be covered in

an alliance plan.

New benefits will be approved slowly and with great difficulty. I am concerned that there will be long bureaucratic delays and major political debates surrounding any attempt to alter benefits. For medical specialty groups, or groups afflicted with particular medical conditions, the National Health Board and, inevitably, Congress will become the central focus of intense lobbying over the addition or subtraction of medical benefits, further compounding the politicization of the health care system.

I believe we can avoid these problems by allowing the consumer their own choice of doctor and health care plans. We can do this by ensuring portable, universal access to health care, regardless of pre-existing conditions and without mandating specific benefits.

Again, I would like to welcome our witnesses here today. I look

forward to their testimony.

Senator BINGAMAN. Thank you all very much. I think it has been a useful hearing.

[Appendix follows.]

#### APPENDIX

### PREPARED STATEMENT OF MARGARET H. JORDAN

Mr. Chairman and Members of the Committee, my name is Margaret H. Jordan. I am Vice-President of Health Care and Employee Services for Southern California Edison (SCE). I appreciate the opportunity to testify today regarding Guaranteed Benefits of the Health Security Act. Southern California Edison is the nation's second-largest electric utility serving four million customers in Central and Southern California. SCE provides health care coverage for more than 55,000 employees, retirees and their family members. Currently, we offer our employees and retirees a choice of six health maintenance organizations and a company administered managed indemnity plan that includes a preferred provider organization (PPO) option. Today, I would like to discuss SCE's interest in having a guaranteed uniform package of comprehensive health benefits provided for in the Health Security Act.

package of comprehensive health benefits provided for in the Health Security Act. Edison, like most large companies, believes that guaranteed comprehensive health benefits are necessary to insure that our employees receive cost-effective health care services in the most appropriate setting. Comprehensive benefits are essential to preventing cost shifting to the most expensive services. They are essential to encouraging preventive care, early diagnosis and treatment. And, a nationally guaranteed comprehensive benefit package is necessary for Edison to provide a equitable package of benefits to all employees wherever they live and work.

It should be noted that these beliefs are shared and supported by the Washington

It should be noted that these beliefs are shared and supported by the Washington Business Group on Health and The National Leadership Coalition on Health Care Reform. Both of these organizations, of which we are members, represent a number

of major corporations who offer similar comprehensive benefit packages.

#### EDISON'S BENEFITS PHILOSOPHY

Edison has structured its plans to promote the health of enrollees and spouses and rely on financial incentives for providers to encourage the efficient delivery of health care. We do not believe in controlling costs by limiting payment for specific treatments. We believe our strategy actually reduces costs by providing care more efficiently, while the strategy of limiting coverage shifts costs to patients who receive certain types of care, whether or not this shift would influence utilization.

Our approach is to select a network of high quality providers, structure financial incentives for those providers to provide care efficiently, and encourage our enrollees to use these providers. In that context, we believe it is more cost effective to offer a full array of treatments, providers, and settings then let the providers decide on the appropriate care. In fact, we will be converting to a Point of Service plan in 1995 with more managed care features. This Point of Service plan will provide an integrated network of providers to further ensure care is not shifted to the least appropriate settings. We believe our comprehensive approach can result in lower cost

health care without compromising quality.

There are several reasons why we think comprehensive benefits produce better care for the patient. First, we believe physicians and patients can make better judgments about appropriate treatment at the point of service than benefits specialists can in the abstract. Physicians and patients should be ultimately in control of the treatment process. Second, covering all treatments, providers and settings enables providers to select the most appropriate and cost-effective care for the patient. Limitations on specific treatments encourages providers to game the system by recoding diagnoses or modifying treatment plans to ensure reimbursement. At a minimum, they bias treatment decisions—creating incentives to use covered treatments whether or not appropriate or cost-effective. Patients who could be better cared for at home may remain hospitalized, patients may choose covered surgery over a less expensive but uncovered pharmaceutical regimen. Third, comprehensive benefits permit continuity in treatment. Patients can be provided appropriate tests, professional care, treatment settings, medical equipment and supportive services without the need to interrupt care, be moved to a different setting, or avoid a treatment due to a limitation in coverage.

Edison is also committed to an emphasis on health promotion and preventive care as critical elements in managing our plan costs over the long run. We believe adequate coverage and financial incentives are necessary to encourage effective screening and use of preventive services. Our Good Health Rebate provides financial incentives to encourage screening and treatment for cardiovascular risk factors has been particularly successful. Since 1989, we have screened over 11,000 health plan enrollees for five cardiovascular risk factors at 60 different screening sites. Our screening has identified 1,500 cases of high blood pressure, 3,000 cases of hypercholesterolemia, and 140 cases of high blood sugar. Half of those identified

with risk factors have followed through with treatment. Among 1,500 cases participating in rescreening, average blood pressure dropped by 10-12 mm/hg and cholesterol by 15-20 mg/dl. We believe that the discovery of this much cardiovascular risk in our population speaks to the value of our program and preventive services.

Screening can be even more effective when directly linked to a primary care provider as a part of routine care. We believe it is cost effective for health plans to cover clinical preventive services according to the procedures and schedules recommended by the U.S. Preventive Services Task Force. While we have not yet proven that preventive care is directly linked to improved health outcomes in our plans, we believe that screening, early diagnosis, and early treatment can be effective in the long run in decreasing the incidence of many chronic diseases, such as diabetics and cardiovascular illnesses.

In the context of capitated payment and systems with at-risk providers and primary gatekeepers, comprehensive benefits are less expensive to provide than "catastrophic" or other restrictive packages of benefits. In fact, in capitated, integrated systems the unrestricted ability of a physician to choose the most appropriate care is essential. Even in an unmanaged environment we believe an attempt to exclude types of treatment or providers from coverage may contribute as much to raising costs as it does to lowering them. Benefit and provider limitations are more likely to favor the most expensive settings (hospitals), treatments (surgery) and providers (specialists) because they are most often considered essential. Rather than narrow coverage, nominal deductibles mitigation can be controlled somewhat in a non-managed context through overuse of repeated sources.

Finally, we believe in providing a uniform package of comprehensive benefits for all of our employees across state lines. A uniform standard is essential to ensure continuous coverage for individuals who move across state lines and to avoid the potential for health benefits to influence locational decisions. We rely upon ERISA to provide us a structure under which we can operate a single plan. A single federal benefit standard is essential to ensure that we can continue to provide equitable and continuous benefits for our employees without regard to their state of residence or work. We support a federal benefit standard because it affords us the necessary pro-

tection from varying state standards.

### EDISON'S COMPREHENSIVE HEALTH BENEFITS

Edison provides comprehensive health benefits to employees, retirees, and dependents comparable to the benefits provided by most Fortune 500 companies. Our benefits package is comparable to the comprehensive benefit package proposed in the President's Health Security Act for Insurance (S1757/H.R. 3600). The Health Security Act would cover virtually all the same service and providers. We cover hospitalization, including related physician and surgical charges; emergency care and ambulance physician office and home visits, including routine physicals, maternity and well-child care; diagnostic tests and laboratory work; prescription drugs; durable medical equipment, and hospice and home health care. In addition, our plan covers mental health and substance abuse through a choice of managed care networks; and chiropractic services with a 50 percent copayment and \$1,750 limit.

Edison offers employees a choice of our managed indemnity plan—HealthFlex—or an HMO alternative. Under HealthFlex, enrollees have a choice of a \$100, \$400 or \$1,000 deductible and can contribute any premium savings to a Health Care Reimbursement Account to pay copayments or other out-of-pocket health costs. Enrollees pay a low copayment of 10% if they use our network of preferred providers, and a higher copayment of 30% if they elect at the point-of-service to use a non-network provider. We make an exception in the case of emergency care and pay the same amount in or out of the network. Enrollees out-of-pocket payments are

limited to \$2,000 for individuals and \$3,000 for families.

Edison's health plan emphasizes preventive services. We cover prenatal care, delivery, and well-child care for children through age six. We also cover clinical preventive services for enrollees and spouses up to \$500 a year. Each enrollee and each spouse can also receive \$150 per year in a Preventive Health Account to pay for preventive services not covered under the plan, including health education, risk reduction programs, screening, diagnostic tests or adult immunizations. Finally, we provide a Good Health Rebate that reduces health plan premiums by \$10 a month for an enrollee or a spouse who is within screening guidelines for five cardiovascular risk factors or who undertakes a program to reduce any elevated risk factor.

### HEALTH SECURITY ACT BENEFITS

The Act includes a few benefits we do not offer (e.g. extended care). It is more restrictive however in the availability of some benefits. For example, the Adminis-

tration would cover hospice and home health care only as an alternative to hospital

or institutional care.

Cost sharing arrangements for their higher cost sharing and combination cost sharing arrangements are similar to our HealthFlex options. Deductibles (\$200 individual/\$400 family) would be between our low and middle deductible options (\$100 and \$400). The Administration would add a prescription drug deductible of \$250, while we include drugs in our overall deductible. Copayments (80/20 in the Administration's higher cost option) would fall between our in-network (90/100) and out-ofnetwork (70/30) copayments. Out-of-pocket limits would be similar—\$1,500/individual for the Administration compared to \$2,000 individual for Edison—\$3,000/family for both. Our cost sharing arrangements for HMOs and the Administration's lower cost sharing schedule are comparable as well.

### CATASTROPHIC BENEFITS

Some health care bills introduced this year have proposed a "catastrophic" health benefit as an alternative to the comprehensive benefits of the Administration's bill. A catastrophic benefit uses high deductibles-\$3,000 to \$5,000 or more-to reduce the premium cost of the package to employers and employees. Often a catastrophic benefit is proposed as a way to slow the growth in health expenditures by requiring individuals to pay for routine medical expenses out of pocket. The assumption is that consumers purchasing with their own money will be motivated to reduce discre-

tionary utilization and select lower cost providers when they do seek care.

Catastrophic benefits lower health insurance premiums and thus lower health care costs for younger people and those with low health risk whose primary health expense is the cost of insurance. At the same time, individuals who become ill, particularly those who develop chronic conditions, pay significantly more in health expenses under a catastrophic plan. The use of high deductibles in the catastrophic approach has the shortcoming that it fails to distinguish between discretionary and necessary care. While higher out-of-pocket payment may discourage some unnecessary utilization, they also seriously tax patients who are in an on-going treatment regimen and receiving regular medical care with no capacity to alter their treat-

Patients rarely have much ability to alter their treatments to save money. Once a condition develops, patients are often under the care of a physician who takes responsibility for referrals to other specialists and decisions about hospital admissions. These decisions are more likely to be influenced by existing contacts or admitting privileges than by objective decisions on cost and quality. Patients rarely have the knowledge or the inclination to second-guess physician recommendations. Thus,

their ability to influence the cost of their care is marginal at best.

While catastrophic benefits do reduce premium costs by shifting some of the cost of care from insurers to individual policyholders, there is no evidence that this cost shift actually reduces utilization in the long run or that it encourages more costeffective use of care leading to better health outcomes. Catastrophic plans could actually increase health expenditures by discouraging prevention and early treatment. Exposure to high out-of-pocket costs may cause individuals to defer treatment until a condition has worsened, and to access specialists directly, foregoing contact with primary physicians who may be able to direct a patient to cost-effective specialists

and manage the overall treatment process efficiently.

The lack of insurance coverage for preventive care is a major shortcoming of a catastrophic approach. While insurance coverage does not guarantee receipt of clinical preventive services, the lack of insurance coverage is clearly a barrier to their use. Furthermore, the addition of coverage for clinical preventive services that are appropriate at specific ages for specific illnesses adds very little cost to the plan. For example, insurance coverage for preventive services recommended by the National Coordinating Committee on Clinical Preventive Services, would add less than three percent to current health care premiums. At the same time, these preventive services have been shown to be an effective way to reduce risk of serious illness that can significantly raise future health care spending.

In a capitated environment, comprehensive benefits provide the physician with the greatest array of tools to treat the patient. Coverage limitations or very high deductibles take many of these tools away from the physician and may force them to bias treatment decisions based on the availability of coverage.

Cost sharing features are appropriate in indemnity or managed indemnity plans as a way to discourage unnecessary utilization of care, but high deductibles are the crudest and least productive way to structure them. Limited copayments can have a greater effect on use of services than deductibles. Copayments can be varied so that the patient's costs are higher for discretionary or self-initiated services, and

lower for hospital care or other services over which the patient has little control. Copayments can also be reduced to encourage the use of preventive care or other service that can help reduce plan costs over time. Limits on the amount of care may also be applied to selected services as a way to trigger a utilization review process. Finally, cost sharing should be varied with income to ensure particularly with respect to low-income families, the transfer to them of costs through cost sharing does

not simply erect insurmountable barriers to the receipt of care.

Cost sharing at levels that are too high simply transfer a greater share of the health care financing burden from the healthy to the sick At some point, this shift in costs from the young to the old and the healthy to the sick erodes the concept of insurance. Insurance is intended to extract financing from people when they are young and healthy to ensure they are able to receive benefits when they are older or sick. Since everyone is at some risk of illness or injury and these events are unpredictable, it makes sense for the young and old alike to maintain health insurance in the event that illness or injury may strike when they least expect it.

#### CONCLUSION

Edison believes strongly, based on our experience in structuring employee health benefit plans and successfully managing their costs, that comprehensive health benefits are necessary to ensure that patients receive cost-effective treatment in the most appropriate setting, that there is continuity in treatment, and that treatment

decisions are not influenced by coverage rules.

Comprehensive benefits can be the most cost-effective approach in the context of a managed care plan that places health providers at financial risk. At the same time, we recognize that truly comprehensive benefits can be expensive in the context of an indemnity plan in which providers have no financial incentive to manage utilization. We believe, however, that attempts to limit coverage may be counter productive because they may result in inappropriate care in inappropriate settings—raising the cost of care and diminishing health outcomes. To the extent that financial incentives for patients are instituted to control costs, we believe copayments are more effective than high deductibles or catastrophic plans in influencing utilization without discouraging diagnosis and early treatment. If the Congress is concerned about the cost of a comprehensive benefit in the context of traditional indemnity plans, we would urge you to reduce the employer's share of the premium-from 80% to 50% perhaps—rather than diminish the benefit package.

Although catastrophic plans have been proposed as a way to provide lower cost plans, we believe they may actually raise health costs eventually by discouraging preventive care and deterring individuals from seeking care until late in the progression of illnesses. Catastrophic plans would be able to reduce premiums for young, healthy participants by shifting costs to participants who are older or sick. While the added out-of-pocket payments might encourage some individuals to reduce discretionary care, most individuals would be simply forced to pay more for nec-

essary care.

We believe instead that it is important to provide adequate coverage for clinical preventive services in order to lower the financial barriers to health education and counseling, immunizations, diagnosis and early treatment—all aspects of our health plans which we believe contribute to a lowering of health risk and long-term health

costs in our corporate plans.

Finally, a comprehensive benefit standard should apply nationwide—both to provide uniform protection to citizens regardless of where they live, and to enable large multi-state employers to operate a coherent and equitable package of benefits for their employees across state lines.

[Additional material is retained in committee files.]

### PREPARED STATEMENT OF CINDY MANN

Thank you for the opportunity to present testimony before you today. My name is Cindy Mann, and I am an attorney with the Massachusetts Law Reform Institute, a poverty law office serving low income people throughout the Commonwealth of Massachusetts. Through my work representing low income people who have been denied health care services, it has become clear to me—as it has become clear to so many others throughout this country—that nothing short of a systematic overhaul of the health care system will produce the kind of changes necessary to ensure access and control costs. It is very exciting that Congress is now debating the merits and the details of a systematic overhaul, but, from the perspective of low income people, people with chronic illnesses and people with disabilities—the most vulnerable of health care consumers—there is grave concern that the outcome of debate might well leave them with only the illusion of coverage. Reform will not have been accomplished or even moved in the right direction if what is enacted is a two-tier

system which imposes substantial costs on people with no ability to pay.

In my work, I see single mothers forced to leave their jobs to reestablish Medicaid eligibility when a child becomes sick and they cannot afford employment-based health care. I see homeless families who cannot get their children seen by a doctor because they do not even have the money to pay for transportation from the shelter to the clinic. I see persons affected with the HIV virus who are still well enough to keep their jobs and their insurance but who, even with insurance, cannot maintain their health because they are being saddled with increasingly unaffordable costsharing requirements for medications and other services.

Only last week, I spoke to a woman who volunteers at a local nonprofit organiza-tion. She suffers from mental retardation and relies on SSI disability benefits. She was sobbing because she needed a prescription filled, but she did not have fifty

cents to cover the Medicaid copayment requirement.

Health care reform will not bring health care any closer to these people unless there is a strong and uncompromising commitment to make a comprehensive package of benefits affordable to them, acknowledging their very limited incomes. The Health Security Act goes far to accomplish the kind of reform that's needed. A comprehensive package of benefits is assured, guaranteeing that people who cannot afford by buy supplemental coverage are not denied services essential to the maintenance or improvement of their health. In addition, the bill takes very important steps to avoid a two tier system of care and to make care affordable. The blended rate structure, the ban on balance billing, the premium subsidies and the reduction in cost-sharing obligations for recipients of cash assistance are critical elements that deserve widespread support. While the bill takes many steps in the right direction in terms of affordability, there is need for improvements, most notably to extend the subsidy for cost-sharing so that all low income people regardless of their source of income are protected. I am hopeful that this Committee will be attentive to revisions which would address these concerns.

My comments this morning will focus on why it is so important that reform not impose unaffordable financing obligations on low income and medically needy people. These comments are offered to encourage you to consider improvements to the Health Security Act, and to urge you to reject proposals which would scale back subsidies and increase cost-sharing obligations for those with no ability to pay. Such proposals are not cost-savers and they are not reasonable transitional measures. They will deny poor children and their families, disabled individuals and other vulnerable people necessary care and cause increased utilization of more expensive care. While offered in the name of reform, such proposals would wed us to an explicitly two-tier system which should be rejected out of hand by all those who think access to health care should be available to all people and not reserved for the more

privileged among us.

Assuring that care is affordable is not inconsistent with the concept that consum-

ers should shoulder some financial responsibility for their care

But the legitimate principle of consumer responsibility should not distract anyone from the fact that some people have little or no ability to pay for care. The call for responsibility or the lure of proceeding incrementally should not create binders to the real-life budgetary pressures faced by low income and vulnerable people. Reform cannot be accomplished if we ignore the very strong relationship between poverty and lack of health care. In the United States today, if you are under age 65 you are five times more likely to be uninsured if your income is below 200% of the poverty line than if your income is above 200% of the poverty line. This is not to say that the problem of universal coverage is one that affects only

low and moderately low income people. To the contrary, universal coverage is now very much on the table because the crisis has gotten so great that very often middle income people are priced out of care; unemployed middle management workers cannot afford COBRA coverage, employees with disabilities or chronic illnesses are locked out of group coverage and cannot afford the cost of non-group coverage; and parents with even moderately well-paying jobs cannot afford the extra premium

costs for covering dependents.

Congress is likely to effectively address the affordability question for most people in these situations, but measures which strike a reasonable financing balance for moderate income people do not necessarily make health care affordable for very low income individuals or for struggling families with children or for disabled or elderly people with limited incomes but extraordinary medical needs. I may be able to afford to pay 20% of the cost of a family premium, but my clients most assuredly can-

<sup>&</sup>lt;sup>1</sup>P. Loprest and M. Gates, "State Level Data Book on Health Care Access and Financing," Urban Institute, 1993.

not. A \$1500 or a \$2000 out of pocket cap may protect me against a catastrophe, but a \$1000 expenditure cap, never mind a \$6000 expenditure cap, offers little comfort to someone who does not have \$10 to spare.

Recently, the Massachusetts Human Services Coalition published a report called "Up the Down Escalator" detailing the monthly budgets of five families, including one relying fully on AFDC and four others with employment income ranging from \$4,420 to \$16,848 a year to support three people—a mother and two children. In all five cases, Medicaid covered medical expenses and yet, considering rent, heat, utilities, food, day care, transportation and a very few other expenses, the families still had monthly shortfalls ranging between \$200 and \$500. Families like these who are living at the margins are already juggling their bills, desperately trying to stay housed and to keep their children clothed. How can they afford yet another expense for health care?

Cost sharing requirements and benefit package guarantees must take into account relative ability to pay for care. A \$10 or \$20 copayment for a family with income at the poverty level is comparable to a \$36 or \$72 copayment for a family at the Massachusetts median income level. suspect that very few, if any, members of Congress would support a proposal to require average income families to pay \$72 each time they needed to see a doctor. Ten dollars is just as unreasonable and even

more impossible for low income families.

Proposals to require low income people to pay more for less benefits turn logic on its head. Such proposals are dangerously short sighted and put the health of the most vulnerable consumers at significant risk. As important as health care may be to families with children, to persons with chronic illness, and to even to persons with life threatening diseases, if you don't have enough money for the rent, for heat, for utilities and for food, or even if you are just squeaking by, there is little or nothing left with which to pay for health care. Faced with the dilemma of paying to see a doctor only at the expense of paying the rent, people will delay care for as long as they can. As the Rand study conducted in the 1970's confirms, unaffordable costsharing obligations imposed on low income people deter access to care. <sup>2</sup>

Perhaps even more significant is a later Rand study, conducted over several years

during the 1980's, which shows that while cost sharing obligations do not necessarily adversely affect the health status of all people, they do adversely affect the health status of low income people. Poor people subject to cost sharing fared significantly worse when evaluated with respect to their vision, their blood pressure and

their overall risk of dying. 3

Given the extent of the financing obligations currently being imposed on millions of low income people, these findings are particularly sobering. The challenge of creating a system which offers a comprehensive range of health care at prices which are affordable to all, however, is more than a humanitarian issue. The fact that delayed and denied care makes people ill or at least less healthy means they are less able to work, less able to care for their dependents, and ultimately much more costly to care for. The full costs are yet to be tallied, but to give you some idea of the scope, let me call your attention to a report released just this week by the Massachusetts Rate Setting Commission showing that, in Massachusetts alone, preventable hospitalizations for illnesses such as asthma and bacterial pneumonia amounted to \$473 million in hospital charges in 1989 and 1990. Financial barriers to care drive up costs and shift responsibility for financing health care in unintended, inappropriate and dysfunctional ways. People in Massachusette.

chusetts paid the \$473 million price tag for these preventable acute care services, in large part because we didn't pay the lower price tag to assure universal and af fordable access to a full range of primary and preventive care. Clearly, neither of the two key goals established by the President and embraced by the public and by most members of Congress-accomplishing universal coverage and reining in health care costs-can be achieved without careful attention being paid to making the

health care that people need affordable to all people.

The concept of personal responsibility is an attractive one, and the pull to reduce the cost of reform by imposing substantial cost-sharing obligations and limiting subsidies will be great. Over the next few months, economic models will be compared,

<sup>&</sup>lt;sup>2</sup>L. Jay Helms, J.P. Newhouse, C.E. Phelps, "Copayments and Demand for Medical Care: The California Medicaid Experience," Rand Corporation under a grant from the Department of Health, Education, and Welfare, February, 1978.

<sup>3</sup>R. Brook, et al., "Does Free Care Improve Adults' Health?", Rand Corporation under a grant from the Department of Health and Human Services, New England Journal of Medicine, Vol 309, No. 23, December 8, 1983.

<sup>4</sup>Massachusetts Rate Setting Commission, "Preventable Hospitalizations in Massachusetts," January, 1994. Significantly, these hospitalizations occurred with much greater frequency in low income communities than they did in higher income communities.

income communities than they did in higher income communities.

utilization assumptions will be questioned, behavioral responses will be projected, and the long- and short-term value of competition will be debated. All this should not cloud one truth that really isn't debatable at all, and that is that people with very low incomes cannot much, if anything at all, for health care. No one should be lulled into believing that we are addressing health care access problems, or that we are ending cost-shifting, or that we are controlling costs, if all we do is offer coverage that received cannot afford to use erage that people most in need cannot afford to use.

# PREPARED STATEMENT OF GAIL SHEARER

Thank you for inviting Consumers Union 1 to testify today on the issue of comprehensive benefits in national health reform legislation. Before addressing consumers' urgent need for comprehensive health benefits that are explicitly listed in legislation, I would like to briefly address the question of whether there is indeed a health care crisis. Mr. Chairman, I know that you need no convincing that there is a crisis. When Consumer Reports analyzed the legislative options under consideration in 1975, two of the five bills covered in our article bore your name. The naysayers—members of a modem day "Flat Earth Society"—may be able to convince themes there is no health care crisis, but rest assured, they can not fool the American consumer. Some symptoms of the crisis:

8.3 million children in this country are uninsured, leaving them without pre-

ventive care, acute care, and rehabilitative care when they need it.

450,000 pregnant women are uninsured, with inadequate prenatal care; many

of them will have low birth-weight babies with a variety of ailments.

Millions of our country's seniors are forced to choose between buying food and buying the medicine that they need, since Medicare does not cover prescription drugs.

35 to 40 million Americans are uninsured, greatly reducing their access to health care, and sending them too often to emergency rooms for urgent care

that could have been avoided with earlier treatment and medicine.

Lifetime policy limits (included in four out of five private policies) keep insurance from providing protection when catastrophic illness strikes, leaving millions of Americans underinsured.

About one third of Americans-75 million people-were either uninsured during 1993 or had direct out-of-pocket health expenses of at least 10 percent of their pretax income [Families, USA].

81 million people have restricted insurance coverage—with exclusions for pre-existing conditions.

There is a health care crisis. Enactment of health reform legislation this year that will provide guaranteed comprehensive benefits to everyone is essential. We simply can not let another generation of America's children grow up without the security

of health care protection.

Consumers Union has been active in the health reform debate for 58 years. We recently prepared a report: "The Clinton Health Care Act: What Will it Means for Consumers." Attached to our testimony is the report's summary of 25 suggestions to improve the Health Security Act. Also attached is a copy of Consumers Union's "Five/Five Plan"—five key provisions to preserve against the pleas of special interest groups and five key provisions that should be improved to better serve consumers. The remainder of our testimony addresses the issue of the need for comprehensive benefits that are explicitly listed in the legislation.

Consumers want comprehensive health care benefits

When Consumers Union commissioned a Gallup survey in April 1993, we received a very clear message from consumers: they want comprehensive health care benefits. Virtually all (close to 90 percent in each case) of those polled favor universal access to a comprehensive health plan that includes: doctor care, hospitalization, prescription drugs, well-child visits and immunizations, nursing home care, long-

<sup>&</sup>lt;sup>1</sup>Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance; and to initiate and cooperate with individual and group efforts to maintain and enhance the quality of life for consumers. Consumers Union's income is solely derived from the sale of Consumer Reports, its other publications and from non-commercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports with approximately 5 million paid circulation, regularly, carries articles on health product sefaty, marketalese conomics and legislative, indigial and required ries articles on health, product safety, marketplace economics and legislative, judicial and regu-latory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

term care at home, mental health treatment, dental care, prenatal care, and vision care. When asked about the possibility of phasing-in health care benefits, at least 75 percent of those surveyed wanted each of these benefits phased-in within four

years, with a strong preference for phasing in doctor care, hospitalization, well-child and immunizations, prenatal care, and prescription drugs within two years.

The survey showed a willingness on the part of consumers to wait somewhat longer for the nursing home and home care benefit—with 50 percent of those polled preferring phase-in within 2 years, an additional 30 percent preferring phase-in within 4 years, and an additional 10 percent supporting a more gradual phase-in of these long-term care benefits. Support for including long-term care benefits went beyond support from people over 65 who are most likely to need the benefit in the near future: fully 91 percent of 18 to 44 year-olds favor including long-term care (both nursing home care and home care) in a benefits package.

Consumers need comprehensive health care benefits: the private market is not up to this important job

In order to achieve true health security, benefits must be comprehensive. Bach family has its own unique health profile and its own set of health care needs. Whether your health need be for a cancer operation, physical therapy to improve the quality of life of a child with cerebral palsy, a measles shot (and other immunizations) to prevent chronic illness in the future, home care for a grandmother with Alzheimer' disease, insulin for diabetes, or medicine to control high blood pressure, every family needs health care of some kind. High deductibles or lack of coverage (for example, preventive care such as childrens' checkups and immunizations are typically not covered by indemnity policies) can present financial barriers to care. As long as there are gaps in coverage, there will be horror stories where the lack of coverage prevented needed treatment and resulted in poor health outcomes or more expensive treatments. If a child's family can not afford needed medicine to control asthma, this child could very likely end up in the emergency room with an asthma attack that is not only life-threatening but also expensive to treat.

The private insurance market is not designed to come to your assistance when you need help. The private market is designed to maximize profits for insurance companies. The cliche that you can't buy rue insurance when the barn is already burning applies to health insurance-once a family needs long-term care, insulin for diabetes, chemotherapy to treat cancer, etc., insurance companies prefer not to take your call. It's clear that what is best for insurance companies is not what's best for

sick consumers.

Only a comprehensive, guaranteed benefits package, covering everybody (regardless of age, health status, income status and employment status) will assure that the gaps that exist in today's health care system will be closed. It is time for an end to the horror stories. Children need their measles shot to prevent serious chronic illness. Pregnant women need prenatal care to avoid having a low birth-weight baby that will be treated at a cost ranging from \$14,000 to \$30,000, or even higher. Kids need early treatment for asthma to avoid that trip to the emergency room. Grandmothers with Alzheimer disease (and their families) need some assistance so that they can remain at home.

Congress should not leave the design of the benefits package to a benefits commission

Only two bills before the Congress-the Wellstone/McDermott single payer bill and the administration's Health Security Act-spell out a comprehensive benefits package. Other bills include broadly described benefit packages (that do not even include prescription drugs 2 and long-term care) and then delegate benefit decisions to a National Benefits Commission (S. 1770, Senator Chafee); a Health Care Standards Commission (S. 1579, Senator Breaux), the National Association of Insurance Commissioners (S. 1533, Senator Lott 3), and the Department of Health and Human Services/state insurance commissions (S. 1743, Senator Nickles) 4.

3 1533 does not call for a standard benefits package, but requires insurers to offer small employers a choice of three plans: standard coverage, catastrophic coverage, or a medical savings account. The NAIC would determine the actuarial value of coverage. Insurers must offer packages that have benefits within 5 percent of the actuarial value calculated by the NAIC

<sup>&</sup>lt;sup>2</sup> 1743 would include prescription drugs in the catastrophic benefits package; but the \$1000 (individual) and \$2000 (family) deductible for a catastrophic policy makes this inclusion meaningless for many consumers.

The benefit package for catastrophic benefits (\$1000/individual and \$2000/family deductible) would include medically necessary acute care, physician services, inpatient, outpatient and emergency hospital services and inpatient and outpatient prescription drugs, but not required to include preventive services, mental health and substance abuse, or long-term care services.

Passing health reform with an unspecified benefits package is like an arranged marriage—you simply don't know what your getting. Consumers Union would never recommend a consumer buy any insurance policy without reading the fine print that could limit coverage. Passing the buck to a commission does not even give the American taxpayer an opportunity to read the fine print, and threatens to reduce the health benefits many people have worked so hard to attain. In order for consumerfriendly health reform legislation to pass in this Congress, broad consumer support is needed. Consumers need to know that they will not be losers under health reform. They need to know that their health benefits will not be cut by reform. This is true both for consumers with employer-provided health benefits and for low-income consumers who are now on Medicaid. It is crucial that the Congress spell out the benefits in the bill.

If Congress defers to either a national commission or the states, you can be sure that special interests will go to work modify the benefits package in their own interest (whether it be to expand or contract benefits). The design of the benefits package

is simply to important for Congress to pass the buck.

Comprehensive benefits will be meaningless if combined with a catastrophic insurance policy

The promise of comprehensive benefits will be hollow if, as in the Chafee, Lott, and Nickles bills, consumers can buy a catastrophic insurance policy, with a \$2000 or \$3000 deductible, and be considered "insured." A \$3000 deductible does not deliver preventive care to children, \$2500 worth of insulin to a diabetic, or many other pressing health care needs.

Many low- and middle-income families will not get access to comprehensive health care. Instead, they will end up with an unfunded Medical Savings Account id a catastrophic policy with a \$2000 or \$3000 deductible. Financial barriers to health care

will continue for these families.

If guaranteed benefits are not comprehensive, there will be a burgeoning supplemental market

If Congress—or even an outside benefits commission—designs a barebones benefits package, the market response is both predictable and alarming. Insurance companies that are excluded from participating in health alliances (probably because they are less efficient and provide less value) will rush in to find their market they are less efficient and provide less value) will rush in to find their market niche—the supplemental market. Employers searching to maintain benefits previously provided will seek out supplemental policies. Individuals that want comprehensive policies will try to buy a policy. All of the problems that have plagued the health care market—and that plagued the medigap market for 25 years before Congress enacted a very successful reform package in 1990—will be shifted to the supplemental market. There will be pre-existing conditions exclusions, denied coverage, frivolous variations in policies. The bottom-line will be a multi-tiered health care system, with the lucky getting herebones coverage, plus supplemental coverage. care system, with the lucky getting barebones coverage plus supplemental coverage, and the unlucky relegated to barebones-only protection. The poor will continue to face financial barriers to needed health care.

If coverage is voluntary, comprehensive standard benefits will not guarantee security

The Congressional Budget Office estimated that last year's version of the Cooper/ Breaux bill would leave 25 million people uninsured in the year 2000. Other bills did even worse. H.R. 5919 (Congressman Michel) would leave 39 million people uninsured in the year 2000 [CBO]. A voluntary plan simply does not offer the security that consumers want. Without mandating an employer contribution, there will never be a level playing field between employers. A comprehensive benefits package is meaningless to you if you are one of the 25 or 39 million people left without any insurance at all. Many supporters of a voluntary approach proclaim the fact that their bill restricts "pre-existing condition exclusions." But in fact, preexisting condition restrictions will continue to exist under reform that is voluntary. As long as there are "pre-existing condition" periods of six months in the voluntary bills, children with diabetes, children in need of therapy, pregnant women, and millions of others who get sick, will have their own horror story to tell about the gaps in the. system. And yet without these preexisting condition restrictions, insurers will be unable to keep consumers from buying health insurance only when they get sick. A voluntary reform approach simply can not close the health care gaps and end the suffering of children and adults who are left out of the system. In sum, the popular slogan of the week regarding crime control, "3 strikes and you're out," can be applied to health care reform:

Strike one: make participation (and employer contribution) voluntary; Strike two: pass the buck on defining benefits to an outside commission; and Strike three: encourage catastrophic policies with a \$3000 deductible.

Any one of these crucial mistakes will totally undermine health care reform, and result in gaps in coverage and continuing suffering, lack of needed health care, and financial barriers to care. We urge your to avoid these mistakes, and assure that consumers' dream for universal, comprehensive health care benefits becomes a reality.

Thank you very much for providing Consumers Union with the opportunity to

present our views.

[Additional material is retained in committee files.]

## PREPARED STATEMENT OF RONALD BURD

Mr. Chairman, and Members of the Committee, thank you for this opportunity to present the views of the Devereux Foundation on the need for a guaranteed package of standard health benefits, and on the benefits that should be included in such a package. I would like to concentrate my comments on mental health benefits.

Devereux commends the Administration for proposing substantial and meaningful improvements in the services offered to persons with mental illness or with developmental disabilities. While we will propose significant changes to the legislation as introduced, we nonetheless believe this proposal has many broad features that are unquestionably in the best interests of the general public and persons with mental disorders.

### BACKGROUND ON DEVEREUX

Devereux, founded in 1912, is a nationwide nonprofit network providing a continuum of high quality treatment services to children, adolescents, and adults who have a wide range of emotional disorders, developmental disabilities, or both. Headquartered in Devon, Pennsylvania, Devereux operates psychiatric hospitals, residential and day treatment programs, school and vocational programs, community-based group homes, therapeutic foster care, as well as individual and family outpatient services through 22 centers located in 13 states and the District of Columbia. This broad array of services and settings—from the most protective to the least restrictive—makes Devereux the largest, most comprehensive non-profit organization of its kind in the nation, and the provider of choice in many states for children and youth.

Understanding that clients have varying abilities, goals and backgrounds, Devereux's multi-disciplinary teams design individualized treatment programs to ensure that each client's experience is therapeutic. Activities are designed to encourage success and achievement and to discourage frustration and failure. The organization's philosophy reflects the legacy of the founder, Helena T. Devereux, a pioneer

special educator, who believed that "every child is a program."

## GENERAL POSITION ON HEALTH CURE REFORM

Devereux agrees with the statement submitted by 31 national organizations to this Committee on November 23, 1993. There should be a comprehensive, flexible package of mental health benefits that are provided through a system of organized care, with a full continuum of services made available which are not subject to arbitrary limits in amount or duration that are not imposed on other health care benefits. In short, Congress should enact the Administration's commitment to full coverage for mental health services on the effective date of the plan, rather than in the year 2001. As discussed in detail below, a comprehensive, flexible mental health benefit is fully justified from financial, medical and moral perspectives. In addition, the current estimates of the costs of this benefit appear to be substantially overstated

Devereux also recommends that Congress focus on the following important items:

Mental health care and related services to children must be improved and coordinated. With more children living in poverty and more and younger children being exposed (often in-utero) to addictive drugs, Devereux is seeing damage from physical and emotional abuse at unprecedented numbers and levels. The direct and indirect costs of unmet mental health care needs are troubling and have been well documented. We believe that fiscally motivated reluctance to address these needs risks even greater expense, both human and financial.

Individuals with special needs who are being served currently should have their benefits protected. Because of the tightening of funding streams at the state and local level, there is a risk of reducing or eliminating appropriate funding for some of those with the greatest need. While this challenge was recog-

nized by the Administration, it is critical that Congress also recognizes the con-

tinuing need to help states, agencies, providers and patients.

A national initiative to research, demonstrate and develop more effective models of treatment is needed. Reliable measurements of care and treatment effectiveness are necessary if managers of care are to achieve "parity" between mental health coverage and other forms of health care insurance. For everyone involved in the delivery system, answers to questions of cost, location and length of treatment have little value without empirical evidence that the patient is, in some measurable way, getting better.

#### NEED FOR LEGISLATED STANDARD BENEFITS PACKAGE

While some bills leave to other entities what specific benefits should be contained in the standard benefits package, we encourage Congress not to avoid this responsibility. As an initial matter, the American public should know what benefits it will receive when it decides whether to encourage the Congress to support, amend, or

oppose the legislation.

Once the bill is enacted, the job of defining the specific standard benefits is simply too important a task to leave to politically unaccountable national health members. While Congress would benefit from a board's review of the benefits package, and while Congress should be required to consider any recommendations for changes to that package, final accountability for what is or is not covered should rest with the elected representatives of the public.

Some will question whether Congress has the expertise to define the benefits effectively. We do not find this argument persuasive. There is a wealth of expertise in the legislative and executive branches and the private sector-all of which have the ability to make their suggestions known to Congress. Deferral to a health board appears to us to be an excuse for avoiding a difficult but critical congressional re-

sponsibility.

### Justification for Comprehensive Benefits

Devereux strongly supports the goal of the Administration to provide a comprehensive, flexible mental health benefit (subject to appropriate management of the benefit), and suggests that the delay until the year 2001 be eliminated. This im-

provement in services can be justified on the following grounds:

1) We are already paying for the costs of untreated mental disorders. Nearly one-third of the nation's homeless persons have a severe mental illness. A majority of the 30,000 suicides in America each year can be attributed to a mental or addictive disorder. In 1990, these were the direct and indirect economic costs of the following conditions: cardiovascular disease, \$160 billion; mental illness, \$148 billion; and respiratory diseases, \$99 billion.3

2) Devereux knows by experience that arbitrary limits on the treatment of persons with serious emotional disturbances are morally and medically undesirable. Treatment based on such limits can prolong the mental illness that originally brought the person into the mental health care system, and can increase the costs to society of that illness. As observed previously before this Committee by Frank B. McArdle,

of the Hewitt Associates: 4

We have found that merely limiting the number of outpatient visits or severely limiting the coverage for mental health or substance abuse has proven to be a short-sighted approach, producing some short-term savings without the appropriate treatment. The results tend to be high relapse and recidivism rates, with employees reentering the system on multiple occasions for the same condition, ultimately compounding the long-term cost problem.

3) Properly administered mental health treatment is effective. Medications such as lithium and clozapine improve a manic depressive or schizophrenic patient's personal and professional life as substantially as insulin improves the life of a person with diabetes. For other patients, residential treatment, partial hospitalization, psychiatric rehabilitation, family therapy, psychotherapy, crisis intervention, day treatment, and in-home services have helped restore the ability to live fulfilling and inde-

Statistics; 1993. Division of Vital Statistics (unpublished data).

<sup>3</sup> National Advisory Mental Health Council, Health Care Reform for Americans with Severe

Mental Illness, 1993 at 50.

<sup>4</sup>Testimony of Frank B. McArdle? Ph.D., before the Committee on Labor and Human Resources, United States Senate, November 8, 1993.

<sup>&</sup>lt;sup>1</sup>Interagency Council on the Homeless, Outcasts on Main Street: Report of the Federal Task Force on Homelessness and Severe Mental Illness, (ADM) 92-1904. <sup>2</sup> U.S. Dept. of Health and Human Services, Public Health Service, National Center for Health

pendent lives. In short, most persons with mental disorders are no longer confined to hospitals to be maintained by long-term custodial care.

#### THE COSTS OF COMPREHENSIVE BENEFITS ARE OVERSTATED

The mental health community was greatly disappointed to see the mental health benefit shrink in response to concerns about its cost. We agree that the mental health benefit should not account for a disproportionate share of the cost of the entire standard benefits package, but we note that estimates of the cost of the present mental health benefit are inaccurate and high. Let us give one example on which we have firm data: inpatient and residential treatment.

We understand that the Health Care Financing Administration (HCFA) assumed that inpatient and residential treatment costs approximately \$800 per day. Devereux, which has 2,000 patients in 22 facilities nationwide, charges a much lower rate, and we are not unrepresentative of other nonprofit organizations provid-

ing similar care.
In order to examine the accuracy of HCFA's assumptions, Devereux conducted a survey of 805 Devereux patients served in five Devereux residential treatment facilities located in four states. These facilities serve young people suffering from serious emotional disturbances: many have multiple diagnoses, and all possess "diagnosable mental disorders" as defined by the Administration bill. Patients sampled were discharged during the two year period between January 1, 1992, and December 31, 1993. All of the facilities surveyed offer a broad continuum of residential treatment programs, from the most restrictive setting (i.e., for acute inpatient care) to the least restrictive setting. The "range of rates" below refer to a wide range of different treatment settings in the residential care context. The results were as follows:

The range of rates at Devereux facilities offering a continuum of residential treatment services (including inpatient acute care) was between \$217/day and

When total patient costs and lengths of stay are compiled, the average cost per day of service at a Devereux facility offering a continuum of residential care

was \$310/day.

Two important points emerge from this data: 1) the \$800/day estimate for acute inpatient care appears to be high by 35%, and 2) the average per-day cost of residential treatment should lower the estimated cost of inpatient care even further. In fact, the significantly lower cost figures for residential treatment would substantiate separating residential treatment from acute inpatient care in the standard benefits package and placing it in its own separate category, if some initial treatment limits are ultimately (and unwisely) retained.

Devereux will be submitting the supporting data for this cost analysis to the Com-

mittee today

It is admittedly possible that an expanded benefit would result in increased utilization-and thus increased costs. Therefore, a proper regime of managed care should be in place which avoids unneeded care while ensuring that patients receive the care they need without encountering unreasonable barriers. The key point is this: proper managed care techniques are more successful at controlling costs than imposition of arbitrary limits on mental health treatment. This has been demonstrated by a number of companies who have taken innovative approaches to improved mental health care coverage for their employees, including Honeywell, Inc., the Digital Equipment Corporation, and Federal Express. 5

#### SPECIAL NEEDS OF CHILDREN

While the arbitrary limits on mental health treatment would have a negative impact on a wide range of persons with mental disorders, these limits would have a

disproportionately adverse impact on children and adolescents.

Most of the children and adolescents that Devereux treats have been referred from local school districts. They are usually found to be disruptive, violent, or performing at substantially below the level that their age and years of schooling would require. They are also usually not responding to any remedial or special education programs that the local school districts provide. Let me emphasize here that school districts wish to avoid referring children to Devereux, because they usually pay for part of any residential treatment, and they have a limited amount of public education funding. Schools would prefer to accommodate the children in their own regu-

<sup>&</sup>lt;sup>8</sup>See, Testimony of Mary Jane England, M.D., President, Washington Business Group on ealth, before the Subcommittee on Health of the Committee on Energy and Commerce, United States House of Representatives, December 8, 1993.

lar or special programs. Thus, there is little likelihood that a comprehensive, flexible mental health benefit for children and adolescents would encourage increased utilization of the benefit because of the financial incentive that schools have to avoid

more expensive care.

We provide treatment to young persons to resolve their emotional difficulties while continuing to provide them with an education that meets the required standards. While the cost of this treatment is not irrelevant, it is more than justified when one compares it to the alternative cost of continual contact with juvenile and adult corrections systems. Quite simply, Mr. Chairman, the juvenile or adult justice system is where many of these children will end up if their disorders are not resolved.

It is our experience that for many children the chances of real progress are greatly enhanced with exposure to a supportive, open residential program. For example, at this writing the average total stay of a child at Devereux's Mapleton Center in Pennsylvania (which provides residential care to children with serious emotional disorders) is 289 days. As current market forces push mental health providers to limit lengths of acute and residential treatment, our lengths of stay are decreasing. However, it must be emphasized that an ill child's chances for real progress are enormously improved when provided access to a continuum of treatment resources which include acute psychiatric hospitalization, all degrees of residential treatment, intensive non-residential programs, and outpatient support coordinated with edu-

cational programming and day treatment.

We offer all of these programs at Devereux. The actual phase of acute hospitalization, critical to stabilizing the child, is usually quite brief—often less than five days—and does little to provide long-term solutions. Rather, Devereux's strength lies in the next step: providing an open residential setting referred to as a "therapeutic milieu." In such a milieu, a multidisciplinary treatment team plans the course of each young person's day to ensure that each experience is therapeutic. A young person's exposure to such treatment often results in positive reinforcement and success for the first time. The milieu approach also allows us to plan for the future resources which will be necessary to support that child and his or her family. The resulting progress is often seen in social functioning with adults and peers, in school work and, ideally, within the family group.

If there is no opportunity to provide this "therapeutic milieu" to the very troubled

children that Devereux treats, these young people will have serious difficulties coping with daily life. The current mental health benefit in the Administration bill does

not provide an opportunity for use of the therapeutic milieu.

## MAINTAINING EXISTING BENEFITS

While the Administration's initial inpatient treatment limit is improperly restrictive, Devereux has been dealing with even more severe limits imposed by the health plans of some patients. Devereux has partially compensated for funding gaps by: 1) use of the Medicaid program by those patients who are eligible, and 2) use of public education funding under the IDEAs law for patients under the age of 21. These sources are limited, however, and large funding gaps remain for many patients. Medicaid is not available to most patients. Public education funding does not fully compensate Devereux for some of the mental health services that are essential in designing integrated programs of formal education, skills training and treatment. And for persons over 21 who are not Medicaid eligible, there is no "gap filler" at all.

At a minimum, Congress should ensure that no harm is done to those persons currently receiving services. While the Administration appears to have recognized this imperative in the mental health area, we must emphasize again that existing IDEA and Medicaid funding provide for essential medical services. Given current proposals to significantly reduce spending on Medicare and Medicaid in order to finance the overall health care plan, Congress should avoid cost shifts which would place the most needy patients below the present "floor" of services provided by the

Medicaid and IDEA programs.

#### ALTERNATIVE BENEFITS PROPOSALS

The sponsors of some alternative health care bills argue that the benefits should be phased in more slowly. Many base their arguments on the suggestions of the

The Individuals with Disabilities Education Act ("IDEA," 20 U.S.C. §1400 et seq.) provides some funds to state and local governments for mental health services to children enrolled in schools.

Jackson Hole Group,7 which has argued that: mental health and substance abuse services should be covered, and advances in deinstitutionalization and drug therapy have improved the variety and quality of services available, but the potential for substantially increased utilization rates and the lack of uniform standards of care and outcomes data makes a benefit without artificial limits financially risky. In April of 1993, the Jackson Hole Group concluded that relatively generous mental health benefits should be phased in over five to seven years, during which the "appropriate use of case management" should be developed. I understand that this suggestion has since been modified simply to require higher copayments for all stand-

ard health benefits during a five-to-ten year transition period. The main problem with this approach is this: during a five to ten year transition period, those who are the most in need of care will receive inadequate care and likely will have relapses and require additional care in the future. This will occur whether there are limits on days of treatment or high copayment requirements which act as barriers to care for many persons. By neglecting appropriate medical or clinical treatment during the transition period, we will artificially inflate the cost of the mental health benefit once the benefit is fully phased in. This approach is similar to failing to pay off a credit card balance initially and allowing the interest charges to mount. Instead of saving money, this approach will and uncesting more charges to mount. Instead of saving money, this approach will end up costing more in the outyears. In addition, this approach will end up fulfilling the prophecy of

those convinced that mental health benefits are too expensive.

A second problem with this approach is the assumption that managed care techniques are not available to replace the arbitrary treatment limitations. As the experiences of Honeywell, Digital, and Federal Express illustrate, effective techniques currently exist. In addition, there will be a four-year period between the date of enactment (1994) and the effective date of the legislation (1998) for dissemination of

these techniques to a broader audience in the work place.

The experiences of these companies also refute concerns that increased utilization (and higher costs) will result if arbitrary limits on mental health services are removed or if substantial copayment requirements are not imposed. Proper managed care techniques have avoided this result for the companies who were innovative enough to attempt to reform their mental health care programs. Why should Congress or the Administration be any less willing to innovate when the likely result appears so positive?

#### ADDITIONAL COMMENTS ON ADMINISTRATION BILL

1) Limitations on Inpatient/Residential Services.

The plan permits extension of inpatient and residential services beyond 30 days only when the patient is a threat to himself or others, needs drug regimen adjustment, or requires somatic therapy. These limited bases interfere with the patient's ability to obtain necessary and appropriate treatment. Medical and psychological necessity should be the criteria for determining length of stay.

2) Restrictions on Intensive Non-residential Treatment.

The intensive non-residential benefit offers a important alternative approach to treating people with serious mental illness. However, it contains contains which make the service difficult to access. The initial 60 days are available by trading them off for inpatient care. This arrangement forces individuals whose illnesses are often unpredictable to reliable the reliable to reliable to relia often unpredictable to relinquish their inpatient safety net to utilize community based intensive services. The choice places an inappropriate decisional burden on people with mental illness. Their choice is likely to be based on fear, rather than clinical propriety.

To use the second sixty days, an individual must pay both a one-day deductible and 50% copayment. Even in the low-copay plans, using the 60 days will cost the individual \$1500, none of which counts toward the out-of-pocket limit on the individ-

ual's total health expenditures.

Further, the four "treatment purposes" in the bill are in conflict with language immediately preceding them that permits the health plan "based on criteria that the plan may choose to employ" to determine that the individual should receive intensive non-residential treatment.

The combination of trade-offs and high copayment requirements diminishes the value of this innovative approach as an alternative to more expensive inpatient care. Only if these services are fully available will consumers have a true choice to utilize the least restrictive environment.

3) Confusion on Psychotherapy Substitution.

William Straub, M.D., On Designing the Initial Uniform Effective Health Benefit Plan (April 13, 1993 Discussion Draft).

The bill attempts to offset an inadequate 30-visit benefit with a provision that allows health plans the discretion to substitute four outpatient psychotherapy visits for one day of hospital care to reduce or shorten hospitalization. It is unclear whether the plan's discretion applies to determining the individual situations where the substitution is applicable or the availability of substitution entirely. If the latter, the provision can create serious adverse selection problems. Patients who reach maximum limits on outpatient psychotherapy (as with other limited services in the bill) are faced with the same difficult and serious situation: no coverage for needed services.

4) Reduction in Collateral Services.

The bill reduces the mental health benefit by including collateral services for family members within the (inadequate) 30-visit limit on psychotherapy. In the October 27, 1993 draft bill, 30 visits for collateral services were in addition to psychotherapy. The draft version should be restored, because visits with family members are often

highly effective means for treating individuals with a mental illness.

5) Copayments and Deductibles.

The poorest and the sickest among us become even more vulnerable when universal access is contingent on payment of deductibles and coinsurance. For many poorer Americans, even the most minimal copayment can be prohibitive. Devereux agrees that individual responsibility is a valuable principle, but it should not become an absolute barrier to essential services to low-income citizens. Requiring 50/00 copayments for inpatient treatment, continued intensive nonresidential treatment, or outpatient therapy and collateral services (under the higher cost sharing schedule) will inhibit access to critical services for some people with mental illness.

Devereux supports the mental health community's proposal for a sliding scale of copayments to help low income people, with adequate subsidies to prevent premiums, deductibles, and coinsurance from becoming barriers to appropriate care. In addition, copayments and deductibles for mental health services should be counted toward the out-of-pocket limit, just as they are for all other benefits in the plan.

#### SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES 8

While this topic is beyond the scope of this hearing, Devereux wishes to mention briefly its support of the Administration's new home and community-based, long-term care program. Any additional services that will allow persons with severe cognitive or mental impairments to be well served at home or in the community are welcome and necessary.

Devereux applauds the Administration for recognizing that not all persons with developmental disabilities will qualify for this new program and thus providing for a continuation of existing Medicaid-based long-term care programs, such as intermediate care facilities for the mentally retarded (ICF/MR). An existing group of patients depends on ICF/MR funded services which cannot be effectively delivered in

the home or community-based environment.

Devereux's concern with the Administration's proposal relates to the new authority for states to combine the new community-based, long-term care program and existing Medicaid community-based and ICF/MR programs into a "single capped program." While Devereux believes that the new emphasis on home and community-based care is appropriate in theory, we are concerned that, in practice, some states will misuse this new authority in order to lower costs by eliminating or severely limiting the availability of "institutional" care. Some patients' day-to-day needs call for more structure than home and community-based services can provide. For these patients, services funded through the ICF/MR program are essential. To ensure the appropriate availability of such services, we believe that the states should be given clear guidelines regarding when a person maybe denied ICF/MR funded services in any "single capped program.

#### DEMONSTRATION PROJECTS

Mental health professionals have long expressed concern about the lack of data measuring the effectiveness, appropriateness, and comparative cost of many current and newly emerging behavioral health care practices. A national research agenda with adequate funding to support demonstration projects is sorely needed. Specifically, Devereux recommends the following three initiatives:

An Effectiveness Demonstration Initiative. This would support demonstration and research projects that assess which services and programs are most effec-

tive and cost efficient for specific disabilities.

<sup>&</sup>lt;sup>8</sup>The most accepted definition of this term appears in section 102(7) of the Developmental Disabilities Act of 1984 (Public Law 98-527).

An Acceptability of Care Demonstration Initiative. We need to examine the acceptability of systems of care to ensure that the recipients of services are sat-

A Continuum of Care Demonstration Initiative. No documented evidence exists to support the belief that all disabled persons can be successfully served in community programs. Devereux recommends demonstration and research projects which will ensure that children and their families receive maximally effective services.

#### SUMMARY AND CONCLUSION

To conclude, Devereux strongly urges the Committee to include a comprehensive, flexible mental health benefit in the standard benefits package which takes effect on the first day that the health care plan is implemented. Devereux also encourages the committee to pay special attention to the mental health needs of children and adolescents, to protect those individuals who are presently receiving services from federal public care systems, and to be conscious of the problem of overly onerous

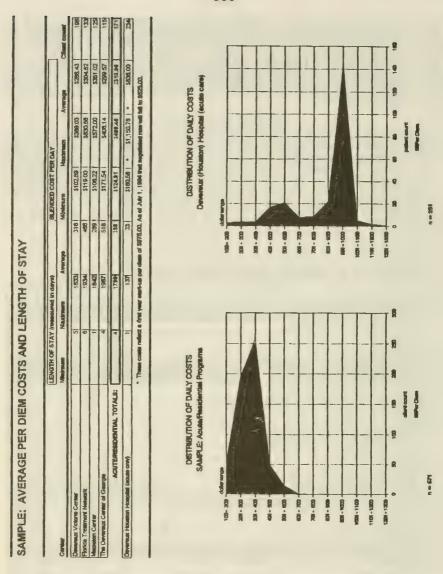
cost-sharing regimens on some persons who need the care the most.

Thank you for this opportunity to present our views, and please accept our offer to provide any additional assistance that you might require.

SAMPLE: CHILD and ADOLESCENT MENTAL HEALTH TREATMENT PROGRAMS

PROGRAM	Per Diam FY 92	Per Diem FY 94
HEROEVERUX VICTORIA CENTRESTIGISTA TRADES LE		4
Children's Psychiatrio Treatment Center	226.00	260.00
Parkdale Lodge	262.00	285.00
Barcley Hall	165.00	285:00
Evaluation & Stabilization	320.00	380.00
是 Homba Telatura le Two in the Sand Habita als challant calle 法是与的执行 called	of Fidenday Bay	
Family Based Treatment/Foster Care - Orlando	N/A	60.00
Family Based Treatment/Individual Residential Treatment - Orlando	N/A	94.00
Family Group Home - Orlando	N/A	100.00
Devereux Village - Orlando	260.00	260.00
Devereux Village - Devereux Hospital Partial Hospitalization - Devereux Hospital	234.00 N/A	260.00
Intensive Treatment Unit - Devereux Hospital	371.00	389.00
Transitional Treatment Unit - Devereux Hospital	371.00	389.00
Evaluation & Stabilization Unit - Devereux Hospital	371.00	389.00
Child's Unit - Devereux Hospital	371.00	389.00
Center for Developmental Disabilities - Devereux Hospital	371.00	389.00
Acute Care Unit - Devereux Hospital	N/A	590.00
MAPLETON CENTER Marken, Fahntylvania		(1)
Mapleton Residential Level III	265.00	276.00
Mapleton Residential Level 11	275.00	286.00
Mapleton Residential Level I	350.00	384.00
Mapleton Psychiatric Institute Level 1	550.00	67.2.00
THE DEVENEUX CENTER OF CLORGIA, Kannes W. Deolina 1922		
Group Home	N/A	161.00
Residential Treatment	210.59	217.00
Intensive Treatment	307.25	316.00
Evaluation & Stabilization	344.02	354.00
PER DEVEATOR HOUSE DAY HOS BIT ALL LABOUR CHAT THE AND THE SERVICE STATE OF THE SERVICE STATE	(1)美东沿线(1)	学生学
Subacute Children	N/A	° 925.00
Subscute Adolescent	N/A	* 925.00
Acute Children	N/A	* 975.00
Acute Adolescent	N/A	* 975.00
Conduct/Behavior Children	N/A	975.00
Conduct/Behavior Adolescent	N/A	975.00
Pervasive Developmental Psychiatric Intensive Care	N/A N/A	° 975.00 ° 1,075.00
Payeniatric intensive care	N/A	1,075.00

These rates reflect first year, start-up per diem rates. As of July 1, 1994 the negotiated rate will fall to \$525.00.



RESPONSE TO QUESTIONS OF SENATOR KASSEBAUM FROM RONALD BURD

# Q. Could you explain how OSCs would provide cost effective mental health care?

OSCs (organized systems of care) would provide the full continuum of mental health service options (i.e., from acute inpatient care to less restrictive inpatient care to various levels of outpatient and community-based services). A "system of care" would provide services that are no more intensive or expensive than medically or clinically necessary. For instance, inpatient hospitalization (costing up to \$800/day) could be minimized or avoided altogether through provision of residential treatment (which averages \$310/day at a Devereux facility).

This "system" or "continuum" would be "organized" through enlightened managed health-care principles. Thus, a responsible provider would monitor the level of care given to each patient to ensure that appropriate care is given but that the treatment is the least restrictive and least expensive that is medically or clinically necessary.

Finally, the system would contain managed outpatient and community-based services to support a person's recovery (i.e., ensuring that treatment goals and medication programs are being followed) so that relapses -- and additional expensive inpatient treatment -- are minimized or avoided.

The cost-efficiency of an OSC is perhaps best illustrated by the inefficiencies of the current non-system. For example, a patient with chronic or severe mental illnesses experiences a serious episode of his or her illness and is hospitalized (at up to \$800/day). Medication and treatment is then given in order to stabilize the person. Shortly, the maximum number of treatment days allowed by the private health insurance plan is reached, and the person must be released to the community. If the patient is lucky, he or she is stabilized. However, there has been no time to treat either the underlying symptoms or the causes of the illness, and there exists no less restrictive or expensive setting in which to provide that treatment. The patient thus runs a very high risk of repeating this cycle and needing expensive inpatient treatment once again. In a short period of time, this cycle of "psychiatric recidivism" — which is quite common today — becomes much more expensive than comprehensive and effective treatment provided in an OSC.

Q. Won't some type of treatment day limits and out-ofpocket payments be needed to prevent over-utilization of care?

Arbitrary limits on treatment are not necessary to prevent over-utilization and create unintended consequences that result in higher costs.

Accountable, professional management of care will ensure that each patient receives the proper amount and level of service and no patient receives too much treatment or more intensive treatment than is medically or clinically appropriate. Organized systems of care are presently providing this form of care and avoiding over-utilization —without having to resort to arbitrary treatment limitations—in a number of private companies (such as Honeywell, Digital, Federal Express), in quasi-public entities (such as the Southern California Edison Company), and in some public Medicaid programs (see answer below).

Imposing arbitrary treatment limits (such as day limits and out-of-pocket payments which are higher than for other medical services) actually end up <u>increasing</u> the cost of mental health care. This occurs because arbitrary limits: 1) prevent provision of adequate care for a mental disorder when it is initially detected, 2) provide for temporary but intensive care that merely "stabilizes" a patient long enough for him or her to be discharged into the

community, and 3) discourage the comprehensive treatment that is necessary to prevent relapses of a mental disorder and to break the cycle of "psychiatric recidivism." The result of arbitrary treatment limits or excessive out-of-pocket payment requirements is repeat usage of the most expensive forms of mental health care (inpatient acute care) over the long-term -- with a resulting increased cost to the mental health care system.

Q: Although OSCs appear to provide cost-effective and appropriate care for the employed, as evidenced by the Federal Express experience, how would the currently unemployed and poor fair in OSCs?

The unemployed and poor would fair as well as the employed in an OSC. While most OSCs now exist in the employment context, that is simply because some employers understand the impact of mental health problems on medical costs and work place productivity and have developed innovative, flexible systems to address them. A recent study released in December of 1993 by Dr. Paul Greenberg of the Analysis Group of MIT determined that depression alone caused annual societal costs of \$43.7 billion, of which approximately one-half is borne by employers in treatment costs and lost productivity.

However, an OSC can function just as effectively outside the employment context, and indeed the various health care reform proposals anticipate this. The Administration plan, the "single-payer" proposal, the Cooper bill and the Chafee bill, all intend to cover the standard medical needs of Americans regardless of their employment status. An OSC is merely the best method of delivering mental health services should some version of any of these bills be enacted.

In addition, the unemployed and poor are the specific targets of managed mental health care reforms contemplated by some public Medicaid programs. Texas and Florida have already begun injecting managed care principles into their mental health programs, and we understand that additional states are also considering this approach. While Texas and Florida have not yet announced results from their initiatives, they clearly viewed enlightened management of care programs as a means to control costs and provide appropriate care. We believe that these initiatives support our belief that the poor and unemployed who need mental health services would fair as well as the employed in an OSC.

#### PREPARED STATEMENT OF EDWIN C. HUSTRAD

Mr. Chairman, the Hay Group appreciates the opportunity to appear before the United States Senate Committee on Labor and Human Resources to discuss the design of health plans of private sector employers and compare these to the proposed benefits of S.1779 which incorporates President Clinton's Health Security Act.

I am the Senior Vice President in charge of the Washington office of Hay/Huggins, the actuarial and benefits operation of the Hay Group. I lead the Hay Group's task force on health care reform. The Hay Group is the actuarial consultant to the Congressional Research Service (CRS). The information included in this testimony will be incorporated in the CRS report on S. 1779.

A primary source for the analysis and information that follows is the 1993 Hay/Huggins Benefits Report (HHBR). The HHBR, an annual report conducted for the last 25 years on the employee benefits programs of over 1,000 employers in the United States, is recognized as one of the most definitive surveys of these programs.

### Benefit Provisions

Traditionally, many basic medical plans were designed to provide individuals with 100 percent reimbursement of the reasonable and customary (R & C) costs for receiving hospital and surgical benefits. Other care, such as prescription drugs, was usually partially covered (coinsured) after the enrollee met a specified deductible. Over the last 15 years, health benefits plans have increasingly applied deductibles and coinsurance to all treatment. Employees have also been asked to take on more of the cost of the premium. These provisions have changed the structure of medical plans today and how individuals will be reimbursed for their covered expenses.

The attached chart compares the provisions of S.1779 with those of plans reported in the HHBR and surveys conducted by the Bureau of Labor Statistics (BLS). This section comments on the typical plan and the following sections quantify the differences between S.1779 and typical private sector plans. The analysis and surveys show the design of an indemnity insurance plan which is still the most prevalent among private sector employers. This plan is compared to the S.1779 high cost-sharing plan which is similar in design to an indemnity plan.

The deductible is the amount an individual must first incur for a medical expense before the health plan will reimburse the individual for allowable health expenses. All indemnity plans have deductibles, but the application of the deductible varies considerably. A deductible can be established as a specified level. Today the most common plan provides for an individual deductible at \$200. Some deductibles are as low as \$100 but others require a deductible of \$300 or \$500 or even more.

The deductible may apply to all benefit provisions in the plan, or, varying deductible levels may be established for specific benefits. For example, a benefit plan may have a \$200 deductible which can be applied towards all medical expenses except for hospital expenses with a separate \$100 deductible. Plans sometimes place separate deductible amounts on surgical, outpatient benefits (doctors visits, x-ray and lab), and mental illness benefits.

After the deductible has been met, an individual will still not receive 100 percent reimbursement of claims that are subject to coinsurance. The most common coinsurance rate used for health benefits is 80 percent. (It should be noted, though, that there are a large number of health care plans that do not have coinsurance provisions for hospital and surgery and reimburse covered individuals at 100 percent of R&C charges for these services.) Like deductibles, coinsurance rates may vary according to type of health benefit being provided. For example, coverage for one hospital stay alone may have three different coinsurance rates; such as, 100 percent reimbursement for room and board; 90 percent for surgery; and 80 percent for x-ray and laboratory and in-patient doctor visits.

As used in health insurance, coinsurance has the, perhaps confusing, meaning of the amount paid by the insurer. S.1779 has substituted the term copayments to refer to any amount a covered individual will need to contribute for the payment of covered health care services. For example, the 20 percent copayment for high copayment benefits under S.1779 is traditionally described as 80 percent coinsurance. This is the same level of benefits being received by the individual - the only difference is how the terms are used.

Provisions are established in most medical plans to prevent financial disaster for the individual by providing 100 percent reimbursement of all expenses once a certain dollar amount is reached. Most often the annual limit will include the deductible amount as well as all coinsurance payments. However, most plans exclude the cost of reimbursing certain medical expenses, such as mental illness benefits, from the annual out-of-pocket limit. Typically, most plans have set individual annual out-of-pocket limits between \$1,000 to \$2,000.

The trends in increasing employee cost sharing in health plans discussed above refer to the most prevalent plan type, the fee-for- service plan. The other major, but less prevalent, plan type is the Health Maintenance Organization(HMO). HMOs, which use a "managed care" cost-saving approach of requiring plan members to have services approved by their "gatekeeping" primary physician, stress prevention, and do not use claim forms, have been growing steadily, both in plans offered by employers, and participation by employees.

Current HMOs are very similar in design, with the exception of dental and prescription drug benefits. Current HMOs provide 100% coverage for approved hospital, surgical, and diagnostic test expenses, although a few plans are starting to use co-payments of some type. Doctors visits typically have a \$5-\$10 required employee co-payment per visit. Inpatient mental illness benefits generally have the same 30 day limit as fee-for-service plans, but are "managed" to sometimes provide less. Outpatient mental illness benefits are more restricted than fee-for-service plans with typically a limit of 10-15 visits per year.

Growing in popularity is a hybrid fee-for-service and HMO plan type. These Point-of-Service (POS) plans permit plan members to use the HMO network or go outside the network and access fee-for-service benefits each time medical services are needed.

S.1779 contains three plan types: the "higher cost sharing" plan which is comparable to current fee-for-service, the "low cost sharing" plan which is comparable to the HMO plan, and the "combination" plan which is comparable to the POS. The S.1779 "low cost sharing" plan benefit is comparable to typical current HMO plan design, with the exception of mental illness benefits which are more extensive under S.1779.

### Relative Value of S.1779 Benefits

The following table compares the value of the S.1779 high cost sharing plan to the value of the range of indemnity plan benefits available in the United States. The information and ranking was derived from surveys published by the Bureau of Labor Statistics (BLS) and the Hay/Huggins Health Care Benefit Value Comparison model that is used for the CRS analysis.

Estimated Percent of BLS Plans Less Valuable than Clinton Proposed Higher Cost Sharing Plan				
Plan Compared Small Medium Stat Large Loc				
Initial with Dental	58%	45%	45%	
Phased-in with Dental	85%	77%	77%	

A fair comparison should focus on two levels of benefits. One is to the initial \$1.1779 plan including dental insurance. That plan is at the 45th percentile of plans in the BLS. (This means that the plan is more valuable than 45 percent of all plans of large employers in the United States and less valuable than 55 percent of those plans.) The plan is at the 58th percentile of plans of smaller employers (less than 100 employees). The percentiles do not include the zero values for employers who do not offer health plans.

The primary reason that the S.1779 plan is below the median of plans of medium and large employers is the fact that 60 percent of plans in the BLS survey provide dental care to both adults and children. S.1779 initially only reimburses dental care for children. The S.1779 plan ranks higher against small employer plans since only 30 percent of these have dental plans.

S.1779 provides a phased-in plan in 2001 that includes adult dental and other improvements. The phased-in plan is at the 77th percentile of medium and large employer plans, and the 85th percentile of small employer plans.

As shown above, the phased in S.1779 plan is more valuable than most plans in any of the surveys. There are two reasons that the plan is more valuable. First, the proposed plan covers preventive services in full. Many private sector plans do not cover preventive services; and, when they do, they charge the same copayments as for other care.

Second, even the initial mental illness benefits are more valuable than those in the private sector. Typical private sector plans limit benefits for inpatient treatment to 30 days and for outpatient treatment to around 30 visits a year. S.1779 also provides 30 days of inpatient and outpatient visits as the floor of care. However, treatment is covered for up to 30 days of additional inpatient treatment when medically necessary; treatment for up to 120 days of intensive non-residential care as a substitute for inpatient treatment; and additional outpatient visits for case management and as a substitute for hospitalization. All of these result in a more valuable mental illness benefit than found in a typical private sector plan.

# Effect of Variations in Benefit Design

In most respects, the S.1779 plan is similar to the typical indemnity benefits offered by employers in the United States. It does, however, contain some features that are more valuable than in the typical plan. And, it contains features that are less valuable than the highest value plans. These features will undoubtedly be carefully considered by Congress in the coming months. We have analyzed the proposed plan to determine changes that would substantially increase or reduce the cost of the plan.

Costs are largely driven by the copayments required of the enrollee. Increasing the copayments reduces the use of care as well as the percentage of costs borne by the health plan. S.1779 uses a copayment structure that is similar to that of the typical plan in the United States. Many plans still provide 100 percent coverage of inpatient hospital and surgery. That change would increase the cost of the S.1779 package by 5 percent.

On the other hand, the cost could be reduced by increasing the share of the costs paid by the enrollee. An increase in copayment from 20 percent to 25 percent of the bill would reduce the premium by 6 percent.

An increase in the deductible to \$300 would reduce the cost by 1 percent. A reduction in the deductible to \$100 would increase the cost by 2 percent. Reducing the maximum to \$1,000 would increase the cost of the plan by 3 percent and increasing the maximum to \$2,000 would reduce the cost of the plan by 3 percent.

Many preventive care procedures are covered in full rather than requiring the 20 percent copayment for other care. Requirement of a 20 percent copayment on these services would reduce the cost of the S.1779 plan by 4 percent.

Mental illness benefits are one of the most controversial parts of health care reform. Mental illness benefits in a well designed and managed indemnity plan cost about 8 percent of the total premium. Removing the limits that are placed on almost all mental illness benefits would increase the share of cost to about 12 percent of the total package.

Mental illness benefits are usually subject to arbitrary limits. For example, the most common plan provides full coverage to 30 days of inpatient care and then no coverage. The result is that many hospital stays are arbitrarily ended at 30 days irrespective of the health of the patient. Carefully designed case management systems can keep the cost in the 8 to 12 percent range without use of arbitrary limits. These systems would have to be put in place by health plans to be competitive within the design of S.1779. Therefore, we believe that the initial and phased-in mental illness packages of S. 1779 can be provided within this range of cost.

The prescription drug package in S.1779 has an unusual design. Most private sector plans either include prescription drugs as part of the basic package of benefits or insure each prescription after a specific payments such as \$5 or \$10. The prescription drug package in S.1779 covers these benefits with a separate deductible of \$250. Including prescription drugs in the basic package of benefits would increase the cost by 1 percent.

The addition of adult dental insurance would increase the premium by 8 percent. Removing the children's dental would reduce the premium by 3 percent.

The following chart illustrates the percentage of change in cost for the benefit variations discussed above.

Effect of Variations in Ber	nefit Design			
Plan Design Change	Percentage Ch	Percentage Change in Cost		
(S. 1779 shown in parentheses)	Increase	Decrease		
Coinsurance (80%) 100% Hospital/Surgical; 80% other 75% Plan Reimbursement	5%	6%		
Deductible (\$200) • \$100 • \$300	2%	1%		
Out-of-Pocket Maximum (\$1,500) • \$1,000 • \$2,000	3%	3%		
Preventive (100%) • 80%		4%		

Effect of Variations in Benefit Design			
Plan Design Change	Plan Design Change Percentage Change in Co		
(S. 1779 shown in parentheses)	Increase	Decrease	
Prescription (\$250 separate deductible)  • Subject to plan deductible	1%		
Dental (Children only)  Add for adults  Remove for children	8%	3%	

In reviewing the above estimates, the Committee should keep in mind that the elements of the health package are interdependent. For example, savings that might be achieved by increasing the deductible could be largely offset by reducing the maximum out-of-pocket limits. While the estimates can be used to approximate the magnitude of a set of changes, pricing of a specific proposal can only be done by considering the package of benefits as a whole.

#### Premiums

The S.1779 plan would require employers to pay 80 percent of the average cost of health plans. The enrollee would pay more or less than 20 percent of the cost depending on the plan chosen but the average would be 20 percent.

While the percentage of employers paying the full cost of health insurance is dropping, in 1993, there were still 39 percent of employers in the HHBR who paid the full cost of employee insurance and 17 percent who paid the full cost of dependent insurance. Almost three-fourths of employers paid more than 80 percent of premium.

As a result, the S.1779 minimum requirement for premium sharing would be less liberal than 75 percent of plans in our survey. However, the proposal would permit employers to pay more than 80 percent.

	S.1779	HHBR Average		eau of Labor & Statist rage Health Benefit Pl	
Benefit Category	High Cost Sharing	Private Sector 1993	Small Employer 1990	State & Local Government 1990	Med - Large Employer 1991
Plan Deductible Per Person (Average) Family	\$200 \$400	\$193	\$178	\$160	\$160
Out-of-Pocket Limits Per (Avorage) Family	\$1,500 \$3,000	\$1,263	\$1,052	\$1,128	\$1,052
Hospitalization Typical Coinsurance Percent with 100% Deductible/Admitting Days Other	80% N/A None 365 80%	80% 21.5% None 365 80%	80% 21.5% None 120 or 365 80%	80% 38.7% None 80%	80% 45.7% None
Surgical - Inpatient/Outpatient	80%	80%	80%	80%	80%
X-Rays & Lab Tests	80%	80%	80%	80%	R0%
Emergency & Accidental	80%	80%	80%	80%	80%
Other Expenses	80%	10%	80%	80%	80%
Prescription Drugs Mail Order Rx Drugs Separate Deductible	80% Yes \$250	Covered in basic plan	Covered in basic plan	Covered in basic plan	Covered in basic plan
Preventive Care Well Baby Care Full Physical Exams Cancer Screening	100% Yes Yes Yes	Yes No No	No No	No No	No No
Routine Tests Gynecological Exam Hearing	Yes Yes No	Yes Yes No	No	No	No
Inpatient Mental Health Days/coinsurance Deductible OOP Limit Life Max	30 max 60/80% cost 1 day None None	30/80% None None None	30 or 60 days	30 days Separate Max	30 daye Separate Max
Outpatient Mental Health Annual limit Visits/Coinsurance	30/80%	\$1,000 limit/yr 23/50%	unknown/50%	<30/50%	<30/50%
Extended Care Facility Home Health Care Hospice	80%-100 days 80% 80%	R0% E0% E0%	60 days/yr 100 visits max \$ limits	60 daya/yr 100 visita max \$ limits	60 dasy/yr 100 vusts max \$ limite

	S.1779	HHBR Average		eau of Labor & Statist rage Health Benefit Pl	
Benefit Category	High Cost Sharing	Private Sector 1993	Small Employer 1990	State & Local Government 1990	Med - Large Employer 1991
Vision Testing & Check-ups Frames & Eyeglasses Contacts	80%-child 80%-child	39% offer scheduled scheduled scheduled	10% offer \$ max/visit dollar limits dollar limits	30% offer \$ max or copay scheduled \$ allowance acheduled \$ allowance	\$ max or copay sched \$ allowance sched \$ allowance
Dental Preventive Restorative Major Restorative Deductible Orthodontia (child)	80%-child 80%-child No \$50 40%	100% 80% 50% 350 30%	30% offer \$1,000 annual limit	60% offer 1,00% 80% 50% Yes	60% offer 100% 80% 50% Yes

Health Benefits as a Percentage of Total Cost under S. 1779		
Benefit Percentage		
Hospitalization	44%	
In-patient Surgical	10%	
Prescription Drugs	3%	
Psychiatric	9%	
Dental	11%	
Other Benefits	23%	

# PREPARED STATEMENT OF DR. WILLIAM H. STRAUB

Thank you for this opportunity to present the views of the Jackson Hole Group on benefit plans.

As you know, the design of the benefit plan will in large measure determine the cost of a national health program. The benefit plan, in effect, defines the product of one of the largest industries in the country and, consequently, will be the primary determinant of the costs of that industry. While we believe that providing a single uniform effective health benefit plan should be the ultimate goal of a national health plan, we strongly suspect that providing a single comprehensive benefit plan to all Americans at the outset, will be necessarily very costly and potentially delay access to those most in need.

Under an employer or individual mandate the costs of a providing single mandated comprehensive benefit plan could be prohibitive for small employers and individuals alike. There is also the danger of locking-in any single, comprehensive benefit plan, and adding benefits is always easier than taking them away.

What alternatives are there?

 One could begin with a single comprehensive (and costly) plan and gradually phase in access as financing permitted, 315

 One could begin with a single less costly plan with early access for all and add benefits as financing permitted.

Alternatively, one could initially offer both a less costly or "Basic Plan" with
a high cost sharing and a more costly "Standard Plan" with low cost sharing.
 We suggest that this approach would more closely balance need and
affordability while facilitating early universal coverage.

The principal disadvantage to offering a choice of two benefit plans is that it would temporarily create a two-tier system.

The principal advantage is that it would facilitate early universal coverage for all Americans.

The goal would clearly remain to arrive at a single uniform benefit plan in 5-10 years once more experience is gained with the costs of each plan, and once reform has produced increased efficiency in our delivery system.

Under this approach, we would require all accountable health plans to offer both the Basic and Standard Plans to minimize potential risk selection problems.

A tax cap could be set at the cost of the Standard Plan which would encourage employers and individuals to buy up to this plan.

Model "Basic" and "Standard" Plans are attached. They differ primarily in the level of cost sharing. It is important to note that both plans are identical in the coverage of preventive services.

The Basic Plan is approximately 25% less costly than the Standard Plan. It is this difference in cost that we feel would facilitate early universal coverage for all Americans.

## MODEL BENEFIT PLANS

# **Cost Sharing Assumptions**

	BASIC PLAN	STANDARD PLAN
Deductible:	\$1,000	\$200
Coinsurance:	70/30	90/10
Out of Pocket Limit:		
Single	\$3,000	\$1,000
Family	\$6,000	\$2,000

Note: The above cost-sharing would apply regardless of whether services were delivered through HMO, PPO, or indemnity plans.

SERVICES	BASIC	STANDARD
Acute Care Facility Services:		
Hospital (Acute)	70/30 (\$200 Ded/Day)	90/10 (\$200 Ded/Stay)
Mental Health / Substance Abuse 30d/10d	70/30	90/10
Emergency Department	70/30	90/10
Surgicenter	76/30	90/10
Diagnostic (Lab/X-Ray)	70/30	90/10
Oncology / Dialysis	70/30	90/10
Professional Services		
Inpatient Visits	70/30	90/10
Office Visits	70/30 \$10 Copay	90/10 \$10 Copay
Psychotherapy	50/50	50/50
Dental (Age 18 and under)	Prevent & Diagnostic 80/20 \$10 Copay	Prevent, Diagnostic, & Fillings 80/20 \$10 Copay
Outpatient Prescription Drugs		
Prescription Drugs	70/30 \$7 50 Copay /30d	90/10 \$5:00 Copay /30d
Extended Care:		
Occupational/Speech Therapy	70/30	90/10
Rehab Services	70/30	90/10
Nursing Home	70/30 (100d)	90/10 (100d)
Hospice Care	70/30	90/10
Home Health Services	70/30	90/10
Durable Medical Equipment	70/30	90/10

Wellness Promotion	Basic	Standard			
Preventative Services:*					
Vell Baby Visits	100%	100%			
Immunizations	100%	100%			
flammography/ PAP / Other Approved Screening Studies	100%	100%			
fision / Hearing Exams	100%	100%			
Pre Natal Visits	100%	100%			
hysical Exams	100%	100%			

\*Preventative Services - Deductible does not apply, but well developed schedules for the recommended and approved frequency of preventive and screening services would apply.

	Exclusions	from Co	overage
•	Eyeglasses or hearing aids.	•	Routine foot care.
	Preventative and restorative dental services	٠	Over the counter drugs.
	for adults (over 16 years).		Private duty nursing services.
•	Dental care, except as required secondary to injury.		Custodial care.
•	Oral Surgery, except for tumor, infection or as required secondary to injury or other medical condition.	٠	Investigational or experimental therapie: procedures, or tests except as approved by the Health Standards Board or AHP.
•	Cosmetic surgery		Specific conditions or circumstances unde which the Health Standards Board or AHF
	Reversal of voluntary stenlization.		determine that otherwise effective treatments have no net benefit.
•	Artificial conception procedures except as approved by plan guidelines (e.g., GIFT or ZIFT for 2 cycles)		Orthodontia, Endodontia, Periodontia

# **Model Plan Costs**

BASIC*		STANDARD*			
Single	Family	Single	Family		
\$106	\$289	\$134	\$366		
\$120	\$327	\$151	\$414		
\$133	\$363	\$159	\$433		
	\$106 \$120	\$106 \$289 \$120 \$327	Single         Family         Single           \$106         \$289         \$134           \$120         \$327         \$151	Single         Family         Single         Family           \$106         \$289         \$134         \$366           \$120         \$327         \$151         \$414	

<sup>\*</sup> The cost-sharing for the Basic Plan is the same whether provided by an HMO or PPO, as it is for the Standard Plan.

# Model Plan Cost Differences:

- The Basic Plan is 25% less costly than the Standard Plan from an HMO; and 18% less costly from a PPO (for the same product).
- The Basic Plan is 27% less costly if received from an HMO rather than a PPO; and the Standard Plan is 20% less costly if received from an HMO rather than a PPO.

# STATEMENT OF STANLEY B. PECK

The American Dental Hygienists' Association (ADHA) is the largest national organization representing the professional interests of the approximately 100,000 dental hygienists across the country. Dental hygienists are preventive oral health professionals, licensed in dental hygiene, who provide educational, clinical and therapeutic services which support total health through the promotion of optimal oral health.

ADHA is pleased that reform of the nation's health care delivery system is one of Congress' highest domestic priorities. We are committed to participating in this process to ensure universal access to cost-effective quality health care, including, at a minimum, preventive oral health services. Oral health is a part of total health and the oral health care delivery system requires reform along with the medical care delivery system.

ADHA is pleased that the Health Security Act proposed by President Clinton includes preventive and primary dental care for children as well as emergency care for both children and adults. However, in light of the proven cost-effectiveness of preventive oral health care -- where each \$1 spent yields \$8-\$50 in savings -- ADHA feels strongly that preventive and other basic oral health care benefits should be provided to adults from the outset. As currently written, the Clinton plan would phase in additional dental benefits for adults by the year 2001.

ADHA has joined the Coalition for Oral Health, which includes approximately twenty-five national oral health organizations, to press for the inclusion of cost-effective oral health benefits in health care reform legislation. The Coalition, using U.S. Public Health Service data, has developed a preventive and primary oral health package for children and adults which would cost a modest less than \$10 per person per month. This package would include: preventive services consisting of a professional oral health assessment, dental sealants, professionally-applied topical fluoride, an annual dental cleaning (oral prophylaxis), and fluoride supplements; acute, emergency dental services; early intervention services (to maintain and restore function) including restorative services and periodontal maintenance services; and certain accommodations for persons with disabilities.

# Access to Oral Health Care

The Institute of Medicine estimates that fifty percent of Americans do not receive regular dental care. Further, while 37 million Americans lack medical insurance, the National Dental Research Advisory Council reports that 150 million Americans lack dental insurance, and millions more are underinsured for health care, including oral health care.

Preventable oral diseases currently afflict the majority of children and adults in our country. Dental caries (tooth decay), gingivitis and periodontitis (gum and bone disorders) are the most common oral diseases. In fact, the Public Health Service reports that fifty percent of all children in the United States experience dental caries in their permanent teeth and two-thirds experience gingivitis. Furthermore, nearly half of all employed adults have gingivitis and eighty percent have experienced periodontitis, according to the U.S. Preventive Services Task Force. If untreated, gum disease causes bone deterioration and eventual loss of teeth, pain, bleeding, loss of function, diminished appearance, and possible systemic infections. Indeed, as many as four to fifteen percent of American adults, and more than forty percent of the elderly, have lost all their teeth. These individuals frequently experience nutritional deficiencies as a result of being unable to chew food. Each of these oral health disorders -- dental caries, gingivitis and periodontitis -- can be prevented through regular preventive care.

Universal access to oral health services should be provided to all Americans as one way to support total health. Ideally, everyone should have access to diagnostic, preventive, restorative and periodontal care, as well as emergency care to treat pain. At a minimum, however, preventive services should be available as an investment for long-term savings.

Children, in particular, should be assured regular preventive services. The American Academy of Pediatrics supports a fully funded preventive care benefit package -- which includes preventive dental care -- as a component of its recommended basic benefit package for children. The Medicaid Early and Periodic Screening Diagnosis and Treatment (EPSDT) program also recognizes the value of preventive oral health care for children, mandating coverage of these services for all Medicaid-eligible individuals from birth to age 21. Because of financial and other restrictions imposed by states, however, the September 1989 "Public Health Service Workshop on Oral Health of Mothers and Children" revealed that the Medicaid program continues to serve only a fraction of the children it was intended to serve.

Preventive oral health care has already proven beneficial. The National Institute of Dental Research (NIDR) reports that one-half of American children ages five to seventeen are now cavity free. Although the prevalence of dental caries among schoolaged children has declined in recent years, 84 percent of 17-year olds were found in a recent NIDR survey to have cavities. Further, the Centers for Disease Control reports that the oral health of African Americans and Hispanics is far worse than that of whites. For example, one of the most severe forms of gum disease -- localized juvenile periodontitis -- disproportionately affects teenage black males and can result in loss of all teeth before adulthood.

Americans with access to preventive dental services highly value this care, as illustrated by federal government workers. The Washington Post recently reported that 1.5 million of the four million current and retired federal workers who participate in the Federal Employees Health Benefits (FEHB) program choose the Blue Cross-Blue Shield policy, in part because of its preventive dental package, which includes dental exams, X-rays, prophylaxis (cleaning) and fluoride treatments. In addition, Hewitt Associates (Hewitt), an international consulting firm specializing in employee benefit plans, reports that 92 percent of the health plans in its data base include dental coverage. Hewitt also reports that employees ranked dental coverage second in importance only to medical coverage and before all other benefits, including paid time off, pension options, sick leave and life insurance.

# Cost Savings Associated With Preventive Oral Health Care

Investing in America's oral health care will translate directly into fiscal savings. It is a known fact that preventive care can reduce the need for expensive critical care. In fact, NIDR reported in July 1992 that Americans saved nearly \$100 billion in dental bills during the 1980s because of improvements in oral health. Again, each \$1 spent on preventive oral health care yields \$8-\$50 in savings.

Remarkably, while economic factors, such as population growth, increases in numbers of dentists, and increases in numbers of Americans with dental insurance, might have significantly increased the growth in dental expenditures over the past decade, National Income and Product Accounts data from the U.S. Commerce Department indicate that average annual growth in total real dental expenditures, adjusted for inflation, was only one percent annually from 1979 to 1989. This was substantially less than growth in medical expenditures. This slower growth in dental expenditures is estimated to have resulted in savings to the American public of more than \$39 billion in 1990 dollars from 1979 through 1989. Increased emphasis on prevention, widespread use of fluorides, and a better-informed public contributed to those cost savings.

Even with these savings, however, there is room for significant improvement. In fact, the American Fund for Dental Health reports that 20 million work days are lost annually due to oral health problems. Increased access to preventive oral health services undoubtedly would reduce this staggering number and exponentially increase cost savings.

A working draft report prepared by the Public Health Service's Oral Health Coordinating Committee entitled "An Essential Oral Health Benefits Package" estimates an annual per capita cost of \$74 to provide all American children with comprehensive oral health services. and all American adults with only acute emergency and preventive services. Thus, the estimated cost of providing these services would be \$19.2 billion for the entire population or \$11.8 for the 160 million Americans who presently lack dental insurance. The report further estimates that extending comprehensive coverage to all Americans would entail a per capita cost of \$134 or \$34.9 billion for the entire population or \$21.5 billion for the dentally-uninsured.

# Role of Dental Hygienists in Providing America's Oral Health Care

As the primary providers of preventive oral health services, dental hygienists stand ready to aid the nation in improving its delivery of oral health care and subsequently contributing to total health by providing valuable services such as routine prophylaxis; periodontal assessment, treatment and maintenance; application of fluorides and sealants; x-rays; and education in self care. By helping patients modify personal health behaviors to promote self care, dental hygienists assist individuals in playing a vital and cost-effective role in their own oral health.

As Congress reforms the health care delivery system, lawmakers thus should not view dentists as the gatekeepers of oral health services, akin to the primary care physician whose status may be elevated to that of gatekeeper of the provision of medical services in the future. The role of a dentist in the delivery of oral health care is not akin to that of a primary care physician. The preventive oral health services which ADHA is advocating be included in a standard benefits package should be available to all Americans when provided by any state licensed provider. Both dental hygienists and dentists are licensed in all 50 states and therefore have demonstrated their competence to the satisfaction of state licensure boards whose mission it is to ensure the health, safety and welfare of the public. Further, dental hygienists receive three times the amount of education in preventive oral health services as do dentists.

Federal legislation should ensure direct access to dental hygienists by providing for direct reimbursement in order to maximize Americans' access to preventive oral health care services. We must break down arbitrary practice setting barriers to access which have long tied oral health care delivery to the fee-for-service private dental office, where only 50 percent of the population is served. Several states, including Colorado and Washington, have endorsed direct access to dental hygienists through legislation which permits dental hygienists to practice independently. These states expressly have recognized that full utilization of the services of dental hygienists can address the need to augment the delivery of oral health care. Federal law in no way should impede the progress that states are making in recognizing that dental hygienists appropriately may provide preventive oral health services outside of the purview of a dental office, thus breaking down the barriers which have impeded access to oral health services for too long.

A 1987 Federal Trade Commission study entitled Restrictions on Dental Auxiliaries, An Economic Policy Analysis recommends the elimination of licensing laws which limit the number of dental hygienists in a dentist's practice, finding that increased use of dental hygiene services will decrease costs to the consumer and improve access, without compromising quality. It is critical for federal legislation to buttress, and not

impede, state law efforts to ensure increased access to dental hygiene services for children, the elderly, minorities, the poor, and the traditionally underserved. Indeed, recently proposed Medicaid EPSDT program rules for dental screening services would provide for referral to a dentist or a professional dental hygienist under the supervision of a dentist as an option to satisfy the requirement for initial referral for dental services. The stated rationale is to "increase the availability of dental services in areas where dentists are scarce or not easy to reach." Any federal legislation that provides for preventive oral health care services must protect patients' direct access to dental hygienists by providing for direct reimbursement.

# Conclusion

In conclusion, preventable oral diseases still afflict the majority of children and adults in our nation, compromising their health and unnecessarily adding to health care costs. Ideally, all Americans should have access to diagnostic, preventive, restorative and periodontal care, as well as emergency care to treat pain. But, at a very minimum, Americans need access to basic preventive oral health care, including education in self care, routine teeth cleaning, provision of fluorides and sealants, periodontal maintenance and routine x-rays. Any federal legislation that provides for preventive oral health benefits also must ensure Americans' access to dental hygienists, the primary providers of preventive oral health care services.

ADHA stands ready to work with the nation's policymakers to ensure every American basic oral health and the savings of billions of health care dollars.

#### STATEMENT OF ROB SCHWARTZ

Dear Mr. Chairman:

My name is Rob Schwartz. I am President of the National Association of Rehabilitation Facilities. We are submitting this statement for the record of your hearing on the guaranteed benefits package included in President Clinton's Health Security Act, S. 1757. NARF is a national organization representing over 900 members who provide medical, vocational, residential and employment services to over 4 million people annually.

Hewitt Associates March 30, 1993 testimony before the House Ways and Means Subcommittee on Health, "HealthCare Reform: Consideration of Benefits for Inclusion in a Standard Benefits Package," stated that it maintains a data base covering the salaried employees of over 1,000 major employers and the hourly and union employees of more than 200 major companies. These employers provide benefits to more than 20 million employees and 35 million of their spouses and dependents.

Services recommended include professional oral health assessment, consisting of thorough examination of the hard and soft tissues of the oral cavity and related structures provided on an annual basis, for those age two and older; dental sealants for permanent molar teeth in children; professionally-applied topical fluoride provided up to twice a year for children and adults who are assessed to be at risk for dental caries; oral prophylaxis (cleaning) for the removal of hard and soft deposits and extrinsic strain; and fluoride supplements made available to children until age 13 whose water supply contains sub-optimal levels of fluoride, acute emergency dental services, dental restorative services, and periodontal maintenance services.

Adult preventive services would include oral health assessment, oral prophylaxis, periodontal maintenance services, professionally-applied topical fluoride for adults at risk for dental caries, and acute emergency dental services.

We appreciate the seriousness with which this Committee is approaching the opportunity to reinvent, reestablish and recreate our health care system. We commend the chairman, the President, and other members of the Senate for tackling this difficult issue. The President's plan takes great steps toward providing health care to numerous people who do not have access to care, including persons with disabilities.

Over four million people receive rehabilitation services annually. Over 80% of these people return to their homes, work, schools or an active retirement. Conditions usually requiring rehabilitation include: heart attack, stroke, arthritis, cancer, neurological disorders, joint fractures and replacements, amputation, head injury, spinal cord injury, chronic pain, pulmonary disorders, burns, multiple trauma and congenital or developmental disorders.

Rehabilitation is delivered in a number of places -- freestanding rehabilitation hospitals, rehabilitation units of general hospitals, comprehensive outpatient rehabilitation facilities, rehabilitation agencies and other outpatient settings, nursing facilities and in people's homes. Determining which setting is appropriate is a function of medical judgment. These settings, properly utilized, can provide a full continuum of rehabilitation care.

NARF has taken the position that any health care reform proposal must:

- Include coverage of comprehensive rehabilitation services;
- Assure that such covered services are in fact available to the people who need them;
- Promote universal coverage;
- · Maintain and improve the quality of care;
- Address costs without compromising the above;
- Assure that people with disabilities have access to health care professionals and other support services they need; and
- Assure that long term services are included in health care reform

The President's plan makes great strides toward these goals. For example, NARF supports:

- Universal coverage;
- · Eliminating preexisting conditions;
- · Making coverage available without regard to health status;
- · Limits on out-of-pocket expenditures;
- · Coverage of inpatient, outpatient and community based rehabilitation services;
- · Prevention initiatives; and
- · Long term services.

Our specific comments on the benefit package follow.

# COMPREHENSIVE BENEFIT PACKAGE (Section 1101 et. seq.)

The Clinton plan proposes a comprehensive benefit package which is to reflect the coverage most people receive today. It proposes coverage of both inpatient and outpatient rehabilitation services which NARF supports. We are pleased to see that the President has recognized rehabilitation. However, we have several comments on the package which we think will enhance it. Coverage of inpatient and outpatient rehabilitation services should provide a full continuum of care for people needing rehabilitation services and ideally they will be delivered as quickly and efficiently as possible to the major benefit and prompt recovery of a patient needing rehabilitation services. The recommendations we have for the comprehensive benefits package are offered with the intention of assuring that the full continuum of care is available to people and in support of achieving the objectives of health care reform.

# A. Inpatient Hospital Rehabilitation Services (Section 1111)

This section covers inpatient and outpatient services provided by a hospital. The term "hospital" is defined by reference to the Medicare Act and includes "an institution...primarily engaged in providing... rehabilitation services for the rehabilitation of injured, disabled, or sick persons." The inpatient hospital services covered are those in section 1861(b)(1)-(3) of the Medicare Act.

Inpatient and outpatient services of rehabilitation hospitals and units must be covered in order to continue the coverage most people have now and enable the uninsured access to such care. The services of rehabilitation units in general hospitals should be covered by virtue of the larger institution being under the more general definition of a "hospital".

Recommendation: NARF supports coverage of inpatient rehabilitation hospitals and units and the services they provide in the hospital services benefit. Report language should include an explicit reference to coverage of rehabilitation hospitals and units and the services they provide under this benefit. A copy of such draft language is attached, as Attachment A.

# B. Extended Care Services (Section 1119)

S. 1757 covers 100 days of extended care services. These would be provided in a skilled nursing or rehabilitation facility. Such coverage is available "as an alternative to inpatient treatment in a hospital after an illness or injury." A rehabilitation facility is defined as "an institution (or distinct part of an institution) which is established and operated for the purpose of providing diagnostic, therapeutic, and rehabilitation services to an individual for rehabilitation from illness or injury".

This definition is virtually the same as that incorporated by reference from the Medicare Act to define a rehabilitation hospital. Thus, the Plan contains an ambiguity. Extended care services are to be provided as an alternative to hospitalization level rehabilitation by an institution that is defined to include rehabilitation hospitals and units.

Recommendation: For purposes of the extended care benefit, "rehabilitation facility" should be defined so that a continuum of care is available for rehabilitation patients, where possible through a single facility. The intensity of nursing and therapy services under the extended care benefit would be less intense than those needed by patients in a hospital level rehabilitation program. The Plan should be clarified to establish that a rehabilitation hospital or a rehabilitation unit in a general hospital can provide these extended care services as a "rehabilitation facility" which will be at a less intense level than is the case for hospital level rehabilitation services. To do so the sentence above should be redrafted to read "such services are covered only as an alternative to inpatient treatment under section 1111." The draft report language in Attachment C also clarifies this point.

#### C. Outpatient Rehabilitation Services (Section 1123)

The Clinton Plan also covers outpatient rehabilitation services provided by entities other than a hospital. "Outpatient Rehabilitation Services" are defined to include physical therapy, occupational and speech therapy to restore functional capacity or to minimize limitations on physical and cognitive function as a result of illness or injury. The need for such services are to be evaluated after 60 days to determine if there is continued improvement in function.

# Recommendations:

- 1. The list of services comprising the Outpatient Rehabilitation Services benefit should include psychology, social services and rehabilitation nursing services when provided by Comprehensive Outpatient Rehabilitation Facilities (CORFs) as defined under Section 1861(cc) of the Social Security Act. The CORF benefit was added to the Medicare Act in 1980 in recognition that rehabilitation is the collective and coordinated application of therapies and other services, rather than a series of individual services.
- 2. Cognitive therapy, audiology and hearing tests should also be added.
- Congenital and developmental disabilities should be added to illness and injury as qualifying conditions for services.
- 4. The 60-day evaluation period should be used only as an evaluation period as is the current practice under Medicare with which the field is familiar, and not be interpreted as a limit.

Specific language implementing these recommendations, is attached as Attachment B. this.

### D. Definition of the Benefit Package

The Clinton plan prescribes coverage of a benefits package, as does, S. 1770 and S. 491. Each of these includes coverage for rehabilitation services. However, several alternative plans, pending in the Congress would leave the determination of benefits to an administrative body.

NARF recommends that coverage be determined by statute.

#### E. Medical Necessity (Sections 1141 and 1154)

In order for any benefits package to work effectively and for the plan to work effectively, the plan requires that only medically necessary services would be made available.

Since the amount of money will be finite and the benefit structure fixed, the only variables available to cut costs are rates of payment to providers and the extent of care provided. Under these circumstances, there is a danger that specialty services such as rehabilitation will be restricted through determinations they are not medically necessary. This is an experience that several facilities have had under current managed care programs, both Medicare and non-Medicare. Accordingly, it is essential that the Plan contain clear and controlling standards for determinations of medical necessity.

Medical necessity is a function of the complexity of the medical, nursing and therapeutic needs of the patient. Services should not be compromised in terms of quantity or time. Medically necessary services are the most cost effective way to return people to their highest level of function and personal safety as soon as possible. The current Medicare hospital inpatient rehabilitation guidelines found in the Medicare Intermediary Manual at Section 3101.11 provide a good basis for determining the need for hospital rehabilitation services. They have been in use for 15 years, are well known and tested. The inpatient guidelines highlight the need for medical management and supervision, skilled rehabilitation nursing and other nursing, intensity of therapies (the hospital level is a minimum of three hours a day, five days a week of P.T., O.T. and other required therapies), plan of treatment and other factors. Additionally, there are outpatient rehabilitation guidelines for physical therapy, occupational therapy and speech language pathology services found in the Intermediary Manual at Sections 3904, 3906 and 3905 respectively.

**Recommendation:** The Medicare coverage guidelines should be adopted for determinations of the need for rehabilitation by alliances and plans. In any event, the determination of medical necessity should be made by the attending physician.

# ADDITIONAL CONCERNS:

# ADMINISTRATIVE STRUCTURE AND QUALITY OF CARE

While this hearing has focused on the issue of covered benefits, there is another factor that relates to benefits. If benefits are covered as recommended above, our concern is that they are actually available to individuals in need of them.

The administrative structure proposed under the Health Security Act is a major change in the structure and delivery of health care services. Essential to this structure is the creation of a national health board, regional and corporate alliances, and accountable health plans. States will play a major role in creating alliances and certifying plans.

The plan encourages the use of health maintenance organizations and other types of managed care plans. Under managed care plans the receipt of services is determined by the decision maker, sometimes referred to as the gatekeeper. Given the constraints on financing, there may be a natural tendency to refer to the least expensive level of care, which may not assure that the most effective outcomes for persons needing services. We would hope, given the opportunity noted above to essentially recreate the health care landscape, that our negative experiences with such organizations, are not carried into this new land.

As reported by our members, our experience with current managed care plans has been problematic. Additionally, there are several studies which show that managed care plans do not deliver all needed medically appropriate services. Let me give you some examples.

A man was riding his bicycle in the Arlington, Virginia area and fell. He suffered a serious spinal cord injury. He is being rehabilitated a local rehabilitation hospital and is insured by a local HMO. While his physician is predicting he will need at least three months of inpatient rehabilitation, his insurance plan will cover only two months. Ironically, as a result, the individual was scheduled to be released from the hospital on Valentine's Day.

In California some years ago, two men suffered spinal cord injuries. One was rehabilitated and returned to his family, job and previous life. His colleague, however, disappeared from rehabilitation one day. The man who received his complete services asked about the second man.

He found that he had been sent to a custodial nursing home where all of the major gains that he had received were lost and was totally dependent. His HMO would only cover 60 days of care and sent him to a rest home. He received no therapies and was turned in bed only once a day.

Additionally, some HMOs do not refer to a comprehensive or acute rehabilitation programs as a matter of practice even though the patient may meet admission criteria. NARF also recently heard that a large risk based HMO will not refer stroke patients to acute rehabilitation but is instead sending them to a nursing facility without the benefit of intensive rehabilitation therapy. This rule of thumb may not be appropriate for all stroke patients. This is particularly true when studies on the cost benefits of stroke have shown considerable savings. A 1981 study showed that for each stroke patient who, through rehabilitation, was able to live at home, the expense of living at home versus a long term residential institutional setting saved \$13,248 per year in 1981 dollars or \$20,447.61 in 1992 dollars. Given that the average stroke patient lives over five years this is a savings of \$102,238.12 in 1992 dollars.

Additionally, a study in California also noted some of the serious problems in failure to refer to rehabilitation services and the quality problems that this presents (Medicare Risk Based Contract HMOs of California: A Study of Marketing Quality and Due Process Rights, Medicare Advocacy Project, Los Angeles, California 90057, January 1993).

Also a recent study by Mathimatica, Inc. raised some serious questions regarding quality of care and referral of appropriate patients to rehabilitation hospitals and units. Medicare patients were being referred instead to skilled nursing homes and it was unclear if their outcomes were as strong as if they had been referred to a comprehensive rehabilitation program.

Finally, NARF recently surveyed its members to determine their experience with managed care. Fifty one out of 57 respondents had contracts for non-Medicare enrolles. Twenty-seven percent of these said that the HMO in their area does not refer these patients to rehabilitation hospitals and units. For Medicare enrolles, of the 31 of the 57 facilities that have contracts with HMOs for Medicare enrolles, 50 percent reported the HMO does not refer Medicare enrolles who need rehabilitation to rehabilitation hospitals and units. Of these, 57 percent report that the HMO takes the position that rehabilitation is not medically necessary.

Therefore, a mechanism must be in place to assure the referral for, and the delivery of, appropriate covered rehabilitation services.

To assure appropriate, high quality services are delivered to persons requiring rehabilitation services, particularly persons with disabilities, national standards must be established. Such standards must be met by states before health plans are approved by a health board or similar entity, and prior to any state certifying a health plan or designating an alliance. These standards must be consistent from state to state and alliance to alliance. The standards that we propose approach this from three perspectives. See Attachment C.

First, they are prospective. They seek to assure that the decision maker, or gatekeeper would have criteria by which to determine immediately if an individual needed rehabilitation services. For example, if an individual came to the gatekeeper with one of the 15 conditions normally requiring rehabilitation services and had a specified functional level, that individual would immediately receive a rehabilitation evaluation. Second, rehabilitation should be included in all medical college and allied health curricula as a mandatory requirement. Third, persons with disabilities should have an opportunity to choose a specialist in rehabilitation as their primary care provider or primary physician from a panel of specialists offered by the plan.

The second set of standards would make sure there are safeguards during the period of receipt of services. These would involve stated times for appointments, follow-up appointments, transportation, etc. The third set of standards would measure the referral of services retrospectively through chart reviews and other quality assurance mechanisms that would then be included in the consumer report card.

NARF has developed specific recommendations on other aspects of the health care plan. They are listed below:

# COVERAGE MANDATE AND DEFINITION OF AN EMPLOYEE (Sections 1001, 1901)

#### Recommendations:

 The Plan should not include in the definition of "employee" persons who are receiving Supplemental Security Income or Social Security Disability Income.

The two-year waiting period for Medicare eligibility by virtue of disability should be eliminated. Persons found to be disabled under Social Security should receive immediate Medicare coverage, retroactive to the date of disability.

Fringe benefit allowances in wage rate on Javits-Wagner-O'Day contracts should be increased as necessary to include the cost of health insurance as mandated by the Health Security Act.

 Rehabilitation facilities and their employees should be eligible for all subsidies in the Plan for payment of health insurance premiums.

# • ADMINISTRATIVE STRUCTURE (Title I, Subtitles C, D, E and F, Part 1)

# A. National Health Board

# Recommendations:

1. The Board should set the standards discussed above.

The membership of the Board should be expanded and include a provider of rehabilitation services, a consumer of rehabilitation services, and a person with disabilities.

# B. State Responsibilities (Section 1200 et. seq.)

#### Recommendations:

1. Rehabilitation providers should be eligible to become specialty providers and centers of excellence in Section 1203(e)(2).

2. Rehabilitation providers should participate with states on all advisory and planning committees.

# C. Health Alliances (Section 1300 et. seq.)

#### Recommendations:

 The patient classification system based on the function related groups (FRGs) system needs to be finalized so that plans, alliances, and providers can negotiate rates and schedules knowing who their patients are and their projected resource use.

2. Plans should also comply with the standards recommended.

3. The Provider Advisory Board should include rehabilitation providers, not just professionals.

4. NARF supports the annual open enrollment period to allow individuals to switch plans if they find their current plan unsuitable. People needing rehabilitation services and persons with disabilities need this flexibility, especially if their plan is not responsive to their needs.

5. Rehabilitation providers should have an opportunity to work with each alliance in developing the outcomes information to be requested. NARF is developing a patient classification system (FRGs) that can predict length of stay based on the patient's functional status at admission. It is being refined to examine functional change from admission to discharge.

NARF supports the role of the ombudsman, but recommends that it be strengthened to assure prompt resolution of enrolles' concerns. Again, our previous experience with managed care

companies and their focus on saving funds has been at the expense of enrolles.

# D. Health Plans (Section 1400 et. seq.)

#### Recommendations:

 To assure referral and delivery of necessary rehabilitation services, plans should meet the standards recommended above.

There should be an adequate number and variety of rehabilitation providers allowed to contract with each plan to assure that a full continuum of care is available to plan enrolles.

3. NARF supports the nondiscrimination provisions which prohibit preexisting conditions clauses and practices that have the effect of attracting or limiting enrolles on the basis of personal characteristics, including health status and the anticipated need for health care, among others.

#### • RISK ADJUSTMENT (Section 1541)

#### Recommendations:

 Add functional ability and assessment to the list of factors used for risk adjustment in order to avoid an impediment to enrollment of persons with disabilities by health plans. Disincentives to enrollment should be removed. An appropriate risk adjustment formula is one factor in removing such disincentives.

2. Rehabilitation providers and persons with disabilities should be represented on the Advisory

Committee for the Risk Adjustment System.

#### • GRIEVANCE MECHANISMS (Title V, Subtitle C)

Recommendation: NARF supports the grievance mechanism in concept and urges that additional safeguards be added for persons with disabilities who do not receive a referral for needed services or are denied such services, to assure they have prompt access to such mechanisms.

### • PLAN PAYMENTS AND BUDGETS (Section 6201 et. seq.)

Recommendation: The Plan should be modified to include a requirement that payments to providers for services covered under the Plan conform to the standard now governing state plans under the Medicaid program (the Boren Amendment). This requires that such rates "are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with State and Federal laws, regulations and quality and safety standards."

#### • MEDICARE COST SAVINGS (Sections 4101 and 4103)

Recommendation: NARF proposes rebasing of TEFRA limits for rehabilitation hospitals and units for a two-year period and adoption of a Medicare prospective payment system for rehabilitation. Furthermore, the types of patients coming to rehabilitation hospitals and units has changed over the last 13 years. To recognize these changes, the current criteria used to define a rehabilitation hospital of unit for exclusion from the PPS should be expanded to add pain, oncology, cardiology and pulmonary.

#### • MEDICARE INTEGRATION (Section 4001)

**Recommendation:** NARF is concerned that allowing, or essentially forcing, Medicare beneficiaries into alliances or managed care plans will jeopardize their ability to receive rehabilitation services. As noted above, NARF has heard from members that the current HMO Medicare contractors are not referring beneficiaries for rehabilitation services.

#### OUALITY MANAGEMENT PROGRAM (Section 5001)

#### Recommendations:

 Rehabilitation's focus is on improved motor and cognitive function which are measurable outcomes. The outcomes information requested should include information on improvement in physical and cognitive functions as well as including vocational and living status.

Rehabilitation providers should be members of and work with the National Quality Management Council and National Quality Consortium, each state, alliance and plan in

developing the outcomes.

Persons with disabilities should be represented on the national council and any other committees charged with developing the quality management program.

Rehabilitation providers should be included in the development of practice guidelines and utilization review protocols at the national, alliance and plan levels.

Rehabilitation providers should be included in the design and conduct of outcomes research which should focus on the resulting quality of life of patients as well as more narrow indicators of functional ability.

# • SUPPLEMENTAL INSURANCE (Section 1421 et. seq.)

Recommendation: Any supplemental insurance should be examined carefully to assure that it does not undermine the continuum of rehabilitation services in the comprehensive benefit package and have an adverse effect on persons needing services. If there is a supplemental insurance program, it should supplement the limits of the comprehensive program and interface with the comprehensive benefits package to assure that care for those who can afford to purchase it is seamless.

# • LONG TERM CARE (Title II, Subtitle B)

Recommendations: NARF supports this new commitment to long term services with an emphasis on home and community based services. NARF also supports the use of multiple eligibility criteria provision of personal assistance services, emphasis on consumer involvement, and the basic philosophy that long term services must be part of a health care reform program.

#### NARF also recommends:

1. Eligibility should be expanded to cover three of five ADLs or four of seven IADLs (mobility, communication, managing money, taking medications, shopping, etc.).

2. NARF supports recognition of cognition as an eligibility factor.

The personal assistance services included under the program look more like personal care services. While a good first step, NARF recommends that states be required to offer a full

range of personal assistance services.

- 4. NARF is concerned that there be no incentives between the alliance based health plan and the LTC plan to limit the rehabilitation services people are receiving under the alliance plan, and move them prematurely to a LTC plan. NARF recommends that, before services are terminated under the alliance plan, there be a separate evaluation to determine if continued functional improvement is possible and that the plan is not terminating them prematurely or for its financial advantage.
- Consumers must continue to have a role in the initial development of plans and services that are delivered at the national, state and individual plan level.

6. There should be a cap placed on out-of-pocket coinsurance payments.

- Psychiatric services required over time which are beyond those covered by the basic benefits package should be addressed.
- Issues regarding state medical practice and nurse practice acts in relation to health-related tasks performed by personal assistance providers such as medication administration and catheterization should be resolved.

# TAX INCENTIVES FOR PERSONS WITH DISABILITIES WHO WORK (Section 2501, 7901)

Recommendation: NARF supports this proposal.

# WORKERS COMPENSATION AND AUTOMOBILE INSURANCE (Title X)

#### Recommendations:

 The bill should acknowledge the diversity of state laws to assure that those states that cover vocational as well as medical rehabilitation services, which may be beyond the Plan's coverage, are recognized and covered.

The definition of a "specialized workers compensation provider" should be amended to include medical and vocational rehabilitation providers as well as occupational health and

occupational therapy.

- Long term care services provided under workers compensation programs should include the support services needed due to a work related disability.
- Rehabilitation must be included in the mission of the Commission on Integration of Health Benefits and Integration.
- 5. Rehabilitation providers should be included in the Commission on Health Benefits and Integration and as consultants to the Departments of HHS and Labor to develop protocols for the appropriate treatment of work related conditions.
- 6. The same recommendations are made for automobile insurance.

# ADMINISTRATIVE SIMPLIFICATION (Section 5130, 4031 et. seq.)

**Recommendation:** NARF supports administrative simplification with the caveat that any additional costs must be paid to providers. Furthermore, for smaller rehabilitation providers, adequate time and funds should be available to allow them to change to electronic billing.

#### • A NEW HEALTH WORKFORCE (Title III, Subtitle A)

#### Recommendations:

- NARF supports all efforts to expand programs, faculty and financial support for those who
  wish to become rehabilitation professionals.
- 2. NARF supports the role of rehabilitation physicians as the primary care physician for persons with disabilities.

#### PREVENTION AND HEALTH RESEARCH INITIATIVES (Sections 3201, 3202)

### Recommendations: NARF supports:

- Continued efforts to reduce disabilities from accidents and environmental conditions, particularly seat belt and helmet laws, smoking cessation and all efforts to contain violence;
- 2. Health research to develop quality and outcomes measures, especially in rehabilitation;
- Programs promoting wellness, including wellness and injury prevention in the work site and in the home; and
- 4. Continued research into long term care.

# DEMONSTRATION OF ACUTE AND LONG TERM CARE INTEGRATION (Section 2601)

**Recommendation:** This program would apply only to people with disabilities and chronic illnesses. NARF believes that if it is to be conducted, it should assure that the same rehabilitation benefits proposed under the comprehensive benefit package and the long term care proposal are included.

# · COST SHARING (Section 1131 et. seq.)

**Recommendation:** Annual and lifetime out-of-pocket expenses must be limited for persons who experience cancer, spinal cord injury, traumatic brain injury or other illness or injury because of the high costs of complications and acute care. Subsidies must be available to persons with disabilities who have low incomes.

#### • LONG TERM CARE INSURANCE (Title II, Subtitle B, Part 3)

#### Recommendations:

- NARF supports development of long term care insurance and that the proposed benefits include rehabilitation and preventive services.
- 2. Non-ambulance transportation should be added as a covered service.
- 3. Such coverage must be supplemental to services under the Plan and not in lieu thereof.

#### REPORT LANGUAGE TO ACCOMPANY THE HEALTH SECURITY ACT

#### Coverage of Inpatient Rehabilitation Services

With regard to inpatient rehabilitation services, section 111 of the bill provides for coverage of hospital rehabilitation. Hospitals providing rehabilitation services, including both rehabilitation hospitals and rehabilitation units in general hospitals, are defined by reference to the definition of "hospital" in section 1861(e) of the Social Security Act. The

bill incudes as inpatient hospital services those under section 1861(b) (1)-(3) which covers all services currently provided by rehabilitation hospitals and units.

Section 1119 of the bill provides for coverage of extended care (EC) services by a rehabilitation facility. The term "Rehabilitation Facility" is defined in 1119(c)(1) to be "an institution (or a distinct part of an institution) which is established and operated for the purpose of providing diagnostic, therapeutic, and rehabilitation services to individuals for rehabilitation from illness or injury." Section 1119(b)(1) of the bill as introduced provided that EC services are covered only as alternative to inpatient treatment in a hospital.

It is the Committee's intent that the bill cover both hospital level rehabilitation services and rehabilitation services in extended care for patients who do not require the level of treatment and intensity of medical supervision of hospital level rehabilitation services provided in rehabilitation hospitals and units. The Committee also feels that providers of inpatient rehabilitation services should be encouraged, or at least permitted, to provide services under both benefits to facilitate continuity of service to patients. To this end the language of 1119(b)(1) has been modified to provide that the EC benefit is covered only as an alternative to treatment under the hospital services benefit. This change is intended to permit a rehabilitation hospital or unit to provide both levels of service.

Unlike the Medicare Act, which bases payment on the type of facility providing service, the Health Security Act does not prescribe methods of determining payments to providers. Methods and rates of payment are left to negotiation between health plans and providers. With regard to inpatient rehabilitation services, the Committee expects that health plans will prescribe standards to differentiate between hospital and extended care rehabilitation services and to vary payment for services accordingly. Currently the Medicare program draws such a distinction in its guidelines for coverage of inpatient hospital services, which specify the intensity of medical supervision, therapy services

and nursing to be provided in hospitals. Such guidelines also require preadmission screening, coordinated care under the supervision of a mulidisciplinary team and improvement of function by the patient to continue treatment. The Committee expects health plans to adopt the same or similar guidelines to distinguish rehabilitation services covered by the hospital services benefit from those covered under the extended care benefit.

### **OUTPATIENT REHABILITATION THERAPY**

# SECT. 1123. OUTPATIENT REHABILITATION SERVICES

- A. COVERAGE. The outpatient rehabilitation services described in this section are:
  - 1. outpatient occupational therapy;
  - 2. outpatient physical therapy;
  - 3. outpatient respiratory therapy; and
  - outpatient speech-language pathology services and audiology services.
- B. LIMITATIONS. Coverage for outpatient rehabilitation services is subject to the following limitations:
  - RESTORATION OF CAPACITY OR MINIMIZATION OF LIMITATIONS. Such services include only items or services used to restore functional capacity or minimize limitations on physical and cognitive functions as a result of an illness, injury, disorder, or other health condition.
  - MAINTENANCE OR PREVENTION PROGRAM. Services described in paragraph (1) include the following outpatient rehabilitation services designed to maintain functioning or prevent or minimize further deterioration:
    - the initial evaluation and periodic oversight of the patient's needs by a qualified rehabilitation health professional;
    - the designing by the qualified rehabilitation health professional of a maintenance or prevention program which is appropriate to the capacity and tolerance of the patient and the treatment objectives;
    - (c) the instruction of the patient, family members, or support personnel in carrying out the program; and
    - (d) reevaluations.
  - 3. REEVALUATION.

- (a) At the end of each 60-day period of outpatient rehabilitation services (other than services described in paragraph (2), the need for continued services shall be reevaluated by the person who is primarily responsible for providing the services. Additional periods of services are covered only if such person determines that the requirement in paragraph (1) is satisfied.
  - (b) Periodically, outpatient rehabilitation services described in paragraph (2) shall be reevaluated by a qualified rehabilitation health professional.

# OUTPATIENT REHABILITATION COVERAGE REPORT LANGUAGE

for Sec 1223 OUTPATIENT REHABILITATION SERVICES, (a) COVERAGE

Coverage of outpatient rehabilitation services includes those services provided by a comprehensive outpatient rehabilitation facility. The comprehensive outpatient rehabilitation facility (CORF) benefit was added to the Medicare Act in 1980 (Section 1861 in recognition that rehabilitation is the coordinated application of therapies and other services, rather than a series of individual services. A CORF is primarily engaged in providing (by or under the supervision of a physician) diagnostic, therapeutic and restorative rehabilitation services. Covered CORF physicians' services; Physical Therapy, include Occupational Therapy, Speech-Language-Pathology, and respiratory therapy; prosthetic and orthotic devices, including testing, fitting, or training in the use of these devices; social and psychological services; nursing care; drugs and biologicals; supplies and durable medical equipment; and other items and services that are medically necessary for the rehabilitation of the individual.

#### PROPOSED PLAN STANDARDS FOR HEALTH CARE REFORM UNDER THE HEALTH SECURITY ACT

Congress, in its directions to the National Health Board, the states, alliances and plans must establish standards that states must meet and that they will require the alliances and plans to meet before the Board approves a state's plan. These standards presume that rehabilitation services are covered in the national benefits package as proposed in the President's plan.

Each plan should have direction and incentives to deliver medically necessary services. One way to
do so is require that when an enrollee sees a primary care provider, the primary care provider must
perform a rehabilitation evaluation within 72 hours for patients who fall into the diagnoses most
commonly treated by rehabilitation or have a congenital disability. These diagnoses include, but are
not limited to, stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma,
hip fracture, brain injury, all forms of arthritis, neurological disorders, burns, cancer, cardiac and
pulmonary diseases and pain.

A second way to assure delivery of services is to require education for primary care providers on rehabilitation. It should be a requirement of their curriculum.

2. Plans must deliver medically necessary rehabilitation services. The standard for medically necessary care must include factors relating to the medical condition of the patient, needed therapy and ancillary services, intensity of medical supervision required, intensity of nursing, improvement in functional capacity, prevention of deterioration and prevention of secondary complications and disabilities. The Medicare inpatient rehabilitation hospital guidelines, Section 3101.11 of the Intermediary Manual, have been used for over 15 year to determine the medical necessity of hospital level rehabilitation services.

- Plans must demonstrate that any financia: rewards must be for the appropriate referral for diagnostic and specialty, such as rehabilitation services.
- Each plan must demonstrate where services will be available so that a full continuum of rehabilitation services is available to enrollees.
- The total quality management program must include an audit to see if patients with typical rehabilitation diagnoses are referred for rehabilitation services.
- Plans must allow all enrollees who have disabilities or chronic conditions to choose a physiatrist or other qualified rehabilitation physician as their primary care provider, care manager or gatekeeper.
- Plans must be required to develop (a) maximum waiting periods for appointments, both initial and followup, and get referrals to specialists; and (b) standards for maximum travel distances.
- 8. Plans must assure that the grievance and appeals procedures be available to both enrollees and providers; that they include short timelines for review of a service denial; and they are clearly communicated to all parties. Plans must have procedures for obtaining an independent second opinion promptly when covered benefits are denied for any reason. Qualified rehabilitation professionals should review any denial of benefits.
- 9. In specific cases, a patient should be allowed to go out of plan for specialized covered services.
- 10. If the plan uses case managers, the case managers working with enrollees who need rehabilitation services must be knowledgeable, trained and educated in rehabilitation.
- Plans must involve rehabilitation providers in the development of utilization review procedures and practice guidelines.

Senator BINGAMAN. The committee stands adjourned. [Whereupon, at 11:30 a.m., the committee was adjourned.]



# THE HEALTH SECURITY ACT: NEEDS OF AMERICANS WITH DISABILITIES

# TUESDAY, FEBRUARY 22, 1994

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 10:02 a.m., in room SD-430, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Harkin, Wellstone, Jeffords, Thur-

mond, and Durenberger.

# **OPENING STATEMENT OF SENATOR KENNEDY**

The CHAIRMAN. Before beginning, we want to extend our appreciation to all the witnesses who are here today for our hearing we had originally scheduled on Friday, December 11. I think, as some of the witnesses well know, there was a bulletin that was put out that said that all nonessential services in Washington were to be closed down, and what do you know, it included the U.S. Senate. While businesses survived, we were not able to hold the hearing without the recorders and other professional support systems. They are obviously necessary to maintain records and to be able to ensure that all the information is collected and distributed to both the members, of the committee and to the Senate. So there was a good deal of inconvenience to many of our witnesses. We were further impressed that all of the witnesses who were expected to be here all showed up, and showed up on time. Our leader, Senator Tom Harkin, who will be here momentarily, had the good opportunity to visit with many of those who were here. I had a chance to listen to many others who made very impressive comments via the telephone, and we did obtain a good deal of information for the record. All of that material would be made a part of this hearing record. Those who were not able to return, their comments would be made a part of the record. I believe all of the initial witnesses have returned for this hearing—an excellent response to this issue.

So we are very grateful to all of you, and we appreciate so much your willingness to share your comments and observations with us. We must ensure that this legislation is truly going to be all-inclusive and meet the extraordinary challenges which face the disability community. The resolution of these issues are so essential and necessary so as to assure persons with disabilities full social participation, respectful of the individual. This is what I believe in—

as I know members of the committee and President believes in as well.

After a brief comment, we will hear from our first witness, Judy

Feder, whom I will say a word about in just a moment.

Today, this committee deals with one of the most critical aspects of health care reform—providing access to health care to those with disabilities. These individuals and their families often have to resort to desperate practices to obtain any kind of health coverage. Many have had to leave successful careers, spend themselves and their families into poverty, or give up caring for their loved ones at home and place them in an institution because that is what their insurance coverage or other programs dictate.

For many others, the opportunity promised by the Americans with Disabilities Act is still a distant reality because of the lack of

available health coverage.

Genuine health reform and universal coverage must be gauged in part by how adequately we deal with people with disabilities or chronic illness. Almost one in five Americans—49 million people—have some form of physical or psychological disability, a disability that challenges them at home or at work on a daily basis; yet less than half of persons with severe disabilities have private insurance as compared to over 80 percent of other Americans. And the severely disabled are forced to rely on our overburdened public health system or else go without health care.

You will be hearing testimony today that will poignantly highlight the stark inadequacy of our current health care system. President Clinton's Health Security Act guarantees basic health benefits to all Americans through broad insurance reforms, guaranteed comprehensive benefit package, and financial subsidies to help lowincome individuals and families afford the coverage. Unquestionably, these provisions correct many of the inequities in our current

system and move us toward real universal coverage.

The President's plan also includes services required by most people with disabilities. These provisions include rehabilitation services, home and community-based services, long-term care services, durable medical equipment, substance abuse and mental health care, support for essential community providers and centers of excellence, and health plan coverage for investigational drugs and research.

Too often, our current system forces people into poverty in order to obtain health care. But under the Health Security Act, all Americans will be able to seek employment without fear of losing the coverage they need.

We are on the threshold of making quality affordable health care a right for every American. It is up to Congress to meet this chal-

lenge, and I intend to do all I can to see that we do so.

We welcome Senator Harkin. I mentioned earlier, Senator Harkin has been our real leader on all issues regarding the disabled in our country. I think all of us on this committee and all Americans are enormously grateful for his tireless advocacy and work in this area.

I will recognize him now.

# OPENING STATEMENT OF SENATOR HARKIN

Senator HARKIN. Mr. Chairman, thank you very much, and I apologize for being a little late this morning. It is one of those winter colds that your kids get, and I had to take her to the doctor

with a sore throat, so I apologize for being a little late.

And let me respond in kind, Mr. Chairman, by thanking you again publicly for your strong support for all the issues that mean so much to the disability community; your strong leadership as chairman of this committee and your support for the Subcommittee on Disability Policy is well-noted throughout the country. You have always been in the forefront of these issues, as you are now in terms of the health care debate and ensuring that the health care reform bill that we do pass does indeed encompass all citizens, including those with disabilities, whether that disability is the result of illness or injury, or whether that illness is a result of a condition existing at birth.

These are some of the issues that we will be discussing today. I also want to thank my colleague Senator Durenberger, who is here today, for all of his strong help and support on the Subcommittee on Disability Policy. It has been great to have him as

a fellow worker in the vineyards on this issue.

We had initially scheduled this hearing a couple weeks ago—maybe you mentioned that in your opening statement, Mr. Chairman—but because of snow and ice, we were unable to have the hearing that day. But I just want to note for the record that you were kind enough to reschedule it at the first opportune time, which was when we came back into session today, and even though this is your birthday—and I think all of us here ought to join me in wishing Senator Kennedy a happy birthday. [Applause.]

The CHAIRMAN. Thank you very much. That is quite a way to

start off.

Senator HARKIN. I have not even made my opening statement

yet. [Laughter.]

I just want to say a couple things before we turn to Ms. Feder. First, the fundamental precept of the ADA is that disability is a natural part of the human experience that in no way diminishes the fundamental right of individuals with disabilities to live independently, enjoy self-determination, or to make choices, to contribute to society, to pursue meaningful careers, and to enjoy full inclusion in all aspects of American life.

It is my expectation that before the close of this year, President Clinton will sign into law equally historic legislation making quality affordable health care a reality for all Americans. Again, this legislation must build upon the precepts of the ADA and make its promises of full inclusion, independence and empowerment a re-

ality for people with disabilities.

There is a compelling need for comprehensive reform in this area. I could go through some examples from my fellow Iowans, such as the parent of a 14-year-old daughter with a kidney transplant who was on Medicaid, but found employment. The insurance coverage offered by the company will not cover her daughter because of her daughter's pre-existing condition.

A man who told me about his dream of starting a small business, but who cannot leave his current dead-end job because his daughter has a disability, and he cannot find an insurance company that will cover his family at a price he can afford.

There are stories like this that are replete throughout this country, and we will be hearing some of those from the panelists this

morning.

I want to commend the President for making an historic commitment to universal coverage for all Americans. But the key features for people with disabilities must include no pre-existing condition exclusions, portability, no work disincentives, community rating, no lifetime caps, limits on out-of-pocket expenses, a guaranteed and specified comprehensive benefits package, and very importantly—and we will discuss this later—access to specialists and other appropriate providers and services regardless of whatever plan an individual might be in, meaningful consumer involvement, and community-based long-term services including personal assistance services.

I want to note for the record that the Health Security Act sent down here by President Clinton contains all of these key features—every one of them. A number of the proposals for health reform before the Congress are seriously deficient in this regard. So our task is to ensure that the final product protects and, where necessary, clarifies and refines these key features. And I know that all of us who are working in the disability community understand that these key features are in the President's bill, and we need to keep those—universal coverage and the fact that people with disabilities need to be protected during the transition to a new system.

Let me reemphasize one more time, Ms. Feder, that we need legislation that includes persons born with congenital disabilities with respect to outpatient rehabilitation therapies, home health care,

and extended care.

So again, Mr. Chairman, if we can craft health care reform legislation that meets the needs of people with disabilities, we can be certain that it will meet the needs of all Americans. So craft the package, and if it meets the needs of people with disabilities, it will

meet every other need in the country.

I know it is going to be a long and hard road to passage, but with your leadership, Mr. Chairman, I know we can do it if we put aside party politics and focus on the needs of people. We did it with ADA, and it was truly a bipartisan effort; we can do it again with health care. We just cannot afford to perpetuate a system that undermines the goals of the ADA. And again, let me very pointedly say that the present system of health care in this country undermines the goals of the Americans with Disabilities Act.

So let us pass health care reform legislation that requires universal coverage of all Americans, including Americans with Disabil-

ities.

Mr. Chairman, thank you very much for indulging me at this time.

[The prepared statement of Senator Harkin follows:]

# PREPARED STATEMENT OF SENATOR HARKIN

On July 26, 1990 President Bush signed into law the Americans with Disabilities Act, landmark civil rights legislation for people with disabilities. The fundamental precept of the ADA is that disability is a natural part of the human experience that in no way diminishes the fundamental right of individuals with disabilities to live independently, enjoy self-determination, make choices, contribute to society, pursue meaningful careers, and enjoy full inclusion and integration in the economic, political, social, cultural, and educational mainstream of American society.

It is my expectation that before the close of 1994, President Clinton will sign into law equally historic legislation making quality,

affordable health care a reality for all Americans.

There is a compelling need for comprehensive reform. Let me share with you just a few stories I've heard from fellow Iowans.

A woman with diabetes who works full time for a company that offers no health care benefits cannot afford both food and the insu-

lin and syringes she needs to treat her diabetic condition.

A parent of a 14 year old daughter with a kidney transplant who was on Medicaid but found employment. The insurance coverage offered by the company will not cover her daughter because of her daughter's pre-existing condition. The parent will have to go back on welfare in order for her daughter to receive the necessary medical treatment.

A man with a disability who had insurance coverage, got sick, and then had his lifetime cap reduced to next to nothing, losing the

security he thought he had.

A parent of a college graduate with a congenital heart defect whose insurance will be discontinued and who cannot afford cov-

erage for her son because the premium is exorbitant.

A man who told me about his dream of starting a small business but who cannot leave his current dead end job because his daughter has a disability and he cannot find an insurance company that will cover his family at a price he can afford.

Each member of Congress must look at the question of whether there is a need for comprehensive health care reform not from the point of view of someone who currently has guaranteed health coverage; rather from the point of view of people like the Iowans above and some of the witnesses that will be presenting testimony today.

I wonder what my colleagues would say if we denied coverage to members of Congress until every American had the security of knowing that he or she had the same guaranteed coverage that we

enjoy.

I commend the President for making a historic commitment to universal coverage for all Americans. Universal coverage means affordable, quality health care for all Americans that can never be taken away. Key features for people with disabilities include no pre-existing condition exclusions; portability of coverage and benefits; no work disincentives; community rating; no lifetime caps; limits on out-of-pocket expenses; a guaranteed and specified comprehensive benefits package; access to specialists and other appropriate providers and services; meaningful consumer involvement;

accountability; and home and community-based long term services,

including personal assistance services.

I am pleased that the Health Security Act contains the key features described above. A number of the proposals for health reform before the Congress are seriously deficient and do not include these features.

The Health Security Act is a vehicle for powerful reform for people with disabilities because it includes all of these key features. Our task is to protect and, where necessary, to clarify and refine, these key features.

We need to ensure that we get real universal coverage, with all

the features described above.

We need to make sure that people with disabilities and chronic conditions are protected during the transition to the new system, and that, once the new system is in place, it reflects and incor-

porates the best practices of the current system.

We need legislation that does not discriminate against persons born with congenital disabilities with respect to outpatient rehabilitation therapies, home care, and extended care. It is unacceptable to cover those who develop an illness or injury during or after birth but not to cover those with the same needs who happen to be born with a disability.

We need to ensure that the concept of prevention set out in the bill includes not only periodicity tables, but also treatment that

maintains functioning and prevents secondary disabilities.

We need to take full advantage of technological advances in items and services that improve functional ability or prevent or minimize deterioration in function for people with disabilities.

We need to ensure that in managed care settings, the gatekeeper will have the qualifications, experience, and equipment necessary to determine the needs of the individual with a disability seeking health care. We must eliminate disincentives to serve people with disabilities and include incentives to serve such individuals.

We need to ensure that our health system meets the needs of all children and families, both in terms of providing prompt access to necessary services, and in terms of offering effective, family-cen-

tered service coordination.

We need to ensure accountability that judges a plan not only on how it treats the average patient; but also based on how it treats those with disabilities and chronic illnesses.

We need to ensure that every entity that has responsibilities under the Act is subject to the civil rights protections set forth in the ADA or section 504 of the Rehabilitation Act of 1973.

We need to recognize that health reform must include long term

care, including personal assistance services.

If we can craft health care reform legislation that meets the needs of people with disabilities, we can be certain that we will

meet the needs of all Americans.

The road to passage will be long and hard. But I believe we can make it if we put aside party politics and focus on the needs of the people. We did it on ADA; we can do it again with health care. We cannot afford to perpetuate a system that undermines the goals of the ADA. Let's make the promise of the ADA a reality. Let's pass

health reform legislation that requires real universal coverage for all Americans, including Americans with disabilities.

For more information, please contact Jodie Silverman or Alex

Sachs at (202) 224-3254.

The CHAIRMAN. Thank you very much, Senator Harkin.

Senator Durenberger?

# OPENING STATEMENT OF SENATOR DURENBERGER

Senator DURENBERGER. Mr. Chairman, happy birthday to you. Let us make it bipartisan, nonpartisan.

The CHAIRMAN. Do you know the best present you could give me,

Dave? [Laughter.]

Senator DURENBERGER. Let us not do that publicly.

The CHAIRMAN. We will not take that up; in our nice bipartisan

spirit, we will let that go just for the moment.

Senator DURENBERGER. Well, anyway, I am pleased to be here with this community again. And Tom, thank you for your comments. It is a pleasure. And I agree with what you said at the end, that if we can do reform that makes health care accessible and affordable to the people with disabilities in our country, then we have accomplished it for everybody in America in a variety of ways.

But I think I would just add one other caveat, and that is that we would probably do it more realistically, because my experience with you on this subcommittee and on the full committee is that this is the place and this is the hearing that deals principally in realism. It gets us off our usual bureaucratic approach to things and regulatory approach to things, and we deal with real life and real situations, and we look at health care in a personal way, not in a political way or something else. I think that is the meaning of what you said at the end.

I liked what you said about portability, no pre-existing conditions, and all those things. That is what brought me to do insurance reform in 1990, 1991, 1992. Now I think it is the one thing that everybody agrees on, is reforming the insurance system and making it more accessible to everybody and more affordable at the same time through guaranteed issue, guaranteed renewal, portability, getting rid of pre-existing conditions, moving in the direction of at least adjusted community rating. A lot of these things, there is no argument about, and that is the wonderful thing about

I would make one last comment. I am not a cosponsor of the President's bill. I am a sponsor of a couple of others. I think ours are more market-oriented. But it is really important to make the point that markets can give you much better medicine than we have today, and they can give it to you at a lot less cost if they were really functioning. But markets cannot do equity. And translated into what our responsibility is, that means fairness; it means equal access for everybody in this country; it means affordability for everybody in this country. It means what the President said in that State of the Union Address about guaranteed access for everybody in this country. Markets cannot do that. Only politicians can do that. And that is us. And whether it is dealing with insurance reform, or it is dealing with Medicaid, Medicare, tax reform, that is our job. That is our job is to do equity and to guarantee acces-

sibility to everybody else. And that is an area in which we still have some disagreement with the President. I do not think the President goes far enough in reforming Medicare and reforming Medicaid and reforming all of these social insurance and tax approaches to the system, and to the extent that he is willing to do that, he is going to find a lot of cooperation there to guarantee that access that he has promised everybody in this country.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator Durenberger. Senator Wellstone?

# **OPENING STATEMENT OF SENATOR WELLSTONE**

Senator WELLSTONE. Thank you, Mr. Chairman. Happy birthday. Thank you for your great work over the years in health care. And I would thank my colleague from Minnesota for his work in this area, and of course, Senator Harkin has been a real champion.

I am going to be very brief. Dr. Feder, I am glad you are here and look forward to what you have to say. Gina McDonald, from the National Council on Independent living, has joined us at some of our meetings, and I am very pleased that she is here today as

well.

Mr. Chairman, I met with a pretty good, really impressive and broad section of the disability community in Minnesota. It was a great meeting because not only did people raise questions, but they handed me six amendments that they had already written up that were very specific. I will not go over all of that, but I think I might just include that as a part of the record.

I do think, Dr. Feder and others, that if I had to summarize their concerns, they were as follows: that the benefits provided not only include curative and rehabilitative care, but also serve to maintain an individual's function and prevent deterioration of his or her condition. I think there is some concern that that support is not there.

Senator Harkin alluded to what is a big, big issue, which is that all people with disabilities, including those with congenital disabilities, must have access to the services they need. That, I think, we absolutely need to be very clear about. And then finally, in the area of assistive technology, we are seeing the potential for enormous breakthrough. I think we still have a lot of work to do in terms of

what we have right now with the President's plan.

Now, there are some other questions, Mr. Chairman, that were raised about some of the copays and the ways in which that may really undercut access to care for low- and moderate-income people within the disabilities community, and we can talk about that as we go along today. But I did want to highlight a few of these concerns, and as someone who is a strong, and every day even stronger, supporter of the single-payer approach, I am also very committed to working with you, as you know, and I think this hearing is extremely important, and I want to make sure that since this is what I consider to be an opportunity of a generation, I want to make sure we do this well.

The CHAIRMAN. Thank you very much, Senator Wellstone.

Senator Jeffords?

# OPENING STATEMENT OF SENATOR JEFFORDS

Senator JEFFORDS. Thank you, Mr. Chairman.

I have an opening statement I would like to make a part of the record, and I would just welcome Dr. Feder. This is a very important area, and I am deeply concerned about the issues with our disabled and the ability to get insurance coverage. I will leave it at that.

[The prepared statement of Senator Jeffords follows:]

# PREPARED STATEMENT OF SENATOR JEFFORDS

Mr. Chairman, the hearing today is one of the most important this Committee will hold. We have taken great strides in the area of discrimination of Americans with disabilities with the passage of the Americans with Disabilities Act, but we still have some to go.

Many of the courageous people who are here to testify sound very much like many of my constituents in Vermont. Time and time again, I hear from people with either a mental or physical disability1 who want to be actively employed. The problem they all face is that since they have a pre-existing condition they are not eligible for employers health benefits. The recent Census report that quantifies that only 48 percent of persons 15-64 with severe disabilities have private health insurance, compared with 80 percent of the non-disabled population, was still a shock to me. With this kind of information, how far have we really come in opening up employment opportunities for people with disabilities if they are ineligible for private employer health insurance? How far have we come if the economic disincentives to work keep people in the public entitlement programs? How much of the federal deficit could be reduced if we fix this part of the system which IS broken?

What is even more discouraging is the testimony of Harry Johnson, Jr. and the family stories Julianne Beckett has included as an addendum to her testimony. When I hear that employers are excluding people from health benefits once they become sick, as was the case with Mr. Johnson, I am appalled. When I hear that employers are firing valuable employees because a child has a debilitating medical condition. I ask how we can allow this to happen in this country? What troubles me the most is that we have a law on the books that is supposed to prevent this type of discrimination in the area of employee benefits called the Employee Retirement Income Security Act (ERISA). Unfortunately, when the Supreme Court allows a case similar to Mr. Johnson's, called McGann v. H & H Music, to stand we have a problem with the law that must be fixed. We will not have any real health care reform unless we prohibit this type of employment discrimination from occurring.

We must accept the challenge posed by Linda Long in her testimony today-"Providing adequate, affordable health care to people with disabilities is a litmus test which will demonstrate the effectiveness of health care delivery in general. If health care reform does not work for the people who most need health care, for whom will it be effective?" Universal coverage is mere rhetoric unless we make health care accessible AND affordable for those who need it

the most.

The CHAIRMAN. Thank you, Senator Jeffords.

# Senator Thurmond?

# OPENING STATEMENT OF SENATOR THURMOND

Senator THURMOND. Mr. Chairman, congratulations. Today is your birthday, I understand. I had one in December, so we are about the same age. [Laughter.]

The CHAIRMAN. I was about to comment that if I can stay around

here as long as you, Strom. [Laughter.]

Senator Thurmond. Mr. Chairman, I have another appointment and cannot stay, but I did want to come and just express my interest in this hearing today. I will review the testimony and assure you that we will give every consideration to the needs of Americans with disabilities.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Before we begin I have a statement from Senator Dodd.

# PREPARED STATEMENT OF SENATOR DODD

Mr. Chairman and Senator Harkin, I thank you for convening this hearing on the important issue of the needs of Americans with

disabilities and health care reform.

Throughout the debate on the family and medical leave act, I heard story after story about people struggling to keep their jobs while caring for a family member with special health care needs. The passage of the family leave bill was an important first step toward providing real security to these families. Real health care reform must come next.

Health care reform offers us an important opportunity to guarantee all Americans coverage and eliminate practices that deny people access to health care when they need it most. While all Americans have a stake in reform, change is especially imperative for Americans with disabilities. I hope and expect that when this session of Congress ends, pre-existing condition exclusions, lifetime limits on care, job lock, risk selection, and other practices that deny people coverage will be a thing of the past.

These changes are of great importance to families with disabled children. no American should live with fear that desperately need protection will soon disappear. No American should live with the terrible knowledge that a lifetime limit on coverage will soon be met. No American should feel compelled to stay in a job only to

maintain benefits he or she can't do without.

The President's health security act includes important provisions for Americans with disabilities. The plan promises a comprehensive benefits package and new long term care benefits. It would also establish a federally funded program offering a broader set of benefits for poverty-level children, who have unique health care needs. Although areas of the plan will undoubtedly require changes, the President has developed a proposal with the needs of the disability community in mind. He should be commended for that.

As this committee reviews and debates health care reform, I expect that we will give the needs of people with disabilities the same level of attention the President has. In particular, I believe it is

particularly important that we review how the plan will help children grow, develop and reach their full potential.

I look forward to discussing these and other issues today, and I

thank the witnesses for joining us to share their views.

The CHARMAN. We want to welcome an old friend and valued counselor for all of us on issues of health care policy in this country. I, like other Republicans and Democrats, value very highly the professionalism and most of all, the caring of Judy Feder in her valuable input on the wide range of health care policy options.

I had the fortunate opportunity to work with Dr. Feder on the Pepper Commission on long-term care issues for our senior citizens. The issues raised are still very much out there as a matter for attention and leadership. I also to had a chance, as other members of this committee, both in this forum and in other forums, to try to find some common ground to deal with these issues which are of central concern to all Americans, and today particularly the disabled.

So we are grateful to you, Judy Feder, for all of the important public service you have provided for our country, and we are look-

ing forward to your testimony and statement here today.

STATEMENT OF JUDITH FEDER, PRINCIPAL DEPUTY ASSIST-ANT SECRETARY FOR PLANNING AND EVALUATION, U.S. DE-PARTMENT OF HEALTH AND HUMAN SERVICES, WASHING-TON, DC

Ms. FEDER. Thank you, Mr. Chairman, members of the committee.

It is a pleasure to be here this morning, as it always is. It is a particular pleasure to honor your birthday, Mr. Chairman, with our discussion of this issue to which you and other members of the

committee are so committed.

The special circumstances of people with disabilities illustrates why it is that the Nation so sorely needs comprehensive health reform. Throughout the process of developing the Health Security Act, we have met many individuals with disabilities and heard some incredible stories about being blatantly denied coverage be-

cause of a disability or an illness.

Many tireless parents of children with chronic severe disabilities have described to us their frustration and outrage at a health care system that has let them down— parents, for instance, who chose not to hospitalize or institutionalize a new baby with lifelong support needs, but to take that child home to live with the family. And what do these parents face in a few short years? They reach their insurance policy's lifetime limit. They can no longer get coverage for the care their child needs, and the entire family may end up bankrupt, with no health insurance at all.

Only comprehensive reform can fully address these problems. What I would like to do briefly this morning is outline for you how

the President's plan would do precisely that.

First, the President's plan guarantees health care coverage that is always there and cannot be taken away. This is perhaps the most positive, significant change for people with disabilities. The Health Security Act assures that no individual faces discrimination in obtaining comprehensive coverage. Health plans will no longer

have lifetime limits on coverage. Health plans will offer open enrollment without charging a higher premium to those with a preexisting condition. And no one will face barriers to care based on disability, race, ethnicity, age, or gender.

Second, the plan offers choices to people with disabilities and their families. Each person can choose a traditional fee-for-service plan, join a network of doctors and hospitals, or join an HMO.

People with disabilities will be further supported by the requirement that all kinds of health plans offer a point-of-service option, the opportunity to use providers beyond those that are included in a managed care network.

Although most people with disabilities may need the same kinds of health care coverage everyone else needs, some people will need highly specialized providers and forms of care. The plan includes special protections to ensure their access to these services. All health plans are required to make sufficient arrangements with providers to assure the provision of all items and services covered by the comprehensive benefit package.

In addition, plans must contract with an academic health center for services that are rare and performed in enough frequency at these sites to ensure quality. Plans must also contract with or reimburse essential providers in the areas they serve. That is those providers that include public health service grantees like community health centers, Ryan White clinics, and so on, that have tradi-

tionally provide care to vulnerable populations.

Further, States may require health plans to contract with Centers of Excellence that they identify in order to further guarantee

appropriate access to care.

And finally, all plans will provide information on their performance and on consumer satisfaction with that performance to enable all consumers and vulnerable consumers to assess the quality of care that health plans provide.

Low-income populations get additional protections beyond those benefits in the guaranteed package. All Medicaid-eligible children will be eligible for a new Federal program of wraparound services

that supplement the comprehensive benefits package.

States will continue to receive matching payments for wraparound services for adults who receive payments from supplemental security income or Aid to Families with Dependent Children, and benefits for people eligible for Medicare and Medicaid

continue as under current law.

The President's plan also offers real hope and tangible support to people of all ages who have disabilities and need communitybased long-term care services. A new program will provide substantial Federal funds to help States offer a wide array of personal assistance and related support to people with severe disabilities, regardless of age or income. Consumers and their representatives will be required to be involved in all aspects of program design, implementation and oversight of the new home and community service program to ensure that it is responsive to people with disabilities.

The President's long-term care plan will also provide tax relief to people with disabilities who want to work but cannot afford the high out-of-pocket costs of the personal assistance services that en-

able them to work.

As you know, comprehensive reform will take a few years to put into place as States implement their reform proposals. During the interim, it is critical that we protect existing insurance coverage for employers and families. We must assure that insurers do not drop the most vulnerable in anticipation of a system in which they are forced to compete based on price and quality rather than on their ability to attract the healthy and avoid the sick.

The Health Security Act therefore includes specific transition protections to guard against the potential egregious abuses that could occur prior to the creation of a fully reformed insurance mar-

ket.

For example, health insurers cannot terminate or refuse to renew coverage unless premiums are not paid or there is evidence of fraud or misrepresentation. So the continuation of coverage is guaranteed.

Insurers have to cover new employees of an employer that pur-

chases coverage regardless of health status.

Premium increases cannot vary based on health status.

Exclusions for pre-existing conditions are limited, and individuals who are continuously insured would not have to meet a new waiting period for pre-existing conditions when switching coverage.

Mr. Chairman, in today's health care system, all of us are at risk of losing our health care coverage and the access to service it assures. People with special needs painfully illustrate the risks that all of us face. We now have a choice. We can either pursue meaningful reform so that the system works for all Americans, or deny or tinker with the problem, letting the system grow more and more unfair, expensive, and out of control.

Mr. Chairman, we know you share our view that the time has come for real reform, and we look forward to working with you to

assure its achievement.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Feder may be found in the appendix.]

The CHAIRMAN. Thank you very much.

We will follow an 8-minute time limit for questions, and then we

will come back if there are additional questions.

As Senator Harkin, I think most of us on this committee have had personal experience with these issues in a very real way. My son Teddy was in an NIH investigative program for treating children's cancer. When the trial was halted, it involved \$2,800 for a 3-day treatment, every 3 weeks for a period of 2 years. Insurance companies did not cover this treatment, and we saw the anguish that parents and families went through in terms of their children. This problem is replicated in other family members with other kinds of physical challenges.

And then there was the matter of Teddy's prosthesis. I remember being with Teddy when he went to a handicapped skiers race. Of 123 children, only four of them had prostheses. The others did not.

We know that it is important for a young person's self-worth to develop and change along with society and peers. And this aside from the psychological problems or the physical problems of a child with chronic medical conditions or disabilities; for example, when he knows he is going to get that chemotherapy or the problems that he has afterward. It is essential to lighten the load by of giving support to all people in our society undergoing such experiences. Furthermore, it is tough enough to deal with some of the problems and challenges that families have to deal with, but is imperative we fashion a program of universal coverage that does what the President and all of us are committed to do. When we talk about universal, we mean universal.

Let me ask a few specific questions. Some of these matters have been touched on by my colleagues, and you are familiar with them. First, many have a concern with being in a system where "gatekeepers" are used in HMOs. For example, are these "gatekeepers" going to be sensitive to the needs of the disability community. Will they have the knowledge, understanding, awareness, and sensitivity when making medical decisions for persons with disabilities. Can we assure that their health needs are responded to. What assurances can you give. Also, to what extent, and in what way, are those concerns addressed?

Ms. FEDER. Well, I think first, Mr. Chairman, it is important to recognize—and we know this from the examination we have conducted over the last year—that many of the best of our organized health delivery systems who offer "gatekeepers," as you have called them, are essentially using those gatekeepers to coordinate quality care efficiently for people with disabilities. And there is a real potential, we believe, with coordination to improve the quality of care for all of us, including vulnerable populations.

Plans under the President's plan will have a real stake in efficient provision of quality care, because we also know that failure to provide quality care often leads to more expensive services that plans will want to avoid. So I think that is the first important feature.

Second is the quality information—

The CHAIRMAN. Excuse me. This is the recognition that by doing this, they are actually saving resources, saving money.

Ms. FEDER. That is right.

The CHAIRMAN. Not only is it wise in terms of the human condition and health needs, but it also results in more efficient pro-

grams.

Ms. FEDER. That is absolutely right, and a key feature of reforming the insurance market so that we are holding health plans accountable for delivering quality services for their enrolled populations, so that we focus their attention on essentially competing to provide quality care and not to avoid risk. That is one of the benefits we derive, which is better quality care at lower cost.

The CHAIRMAN. What assurances, though, can you give to individuals who do not feel they are being attended to in the ways that they feel their physical or mental challenges present? What are the means by which they can at least receive some satisfaction from

the health care system and not going to be shunted aside?

Ms. FEDER. The first are the incentives of the plan; second is information about how the plan performs; and then third are issues, I think, that if they face any difficulties, to assure that they do not have difficulties. I would reiterate or call your attention to all of the specific provisions that requirements be made of plans for adequate contracting for service and access to specialists, for access to the point-of-service option to be able to go to other providers, whether they be traditional providers to vulnerable populations, or just a physician of someone's choice. All of those requirements are

included in the President's plan.

And then, should an individual have a problem, we have included explicit mechanisms to facilitate their getting a response from their insurance plan. There are grievance procedures; a requirement that plans respond within 24 hours; there is an ombudsman available in the community to assist consumers, and all plans are essentially held accountable for delivering the guaranteed benefits to their enrolled population. That is a part of the underlying guarantee in the President's plan.

The CHAIRMAN. Another area has been referred to by Senator Harkin, and that is with regard to disability at birth. Given the particular language which refers to illness and injury, how is the program going to address birth defects and other kinds of health

needs?

Ms. FEDER. I want to be very clear, because I think there has been some misunderstanding, that the language that is a cause of concern is limited to particular benefits that all persons, whether with a congenital condition or any other circumstance, are covered and guaranteed the range of health benefits that is included in the guaranteed benefits package. What is at issue here, the concern that has been raised, has to do with posthospital services, rehabilitation services, home health, and extended care in nursing homes. That benefit, Mr. Chairman, consistent with insurance practices today, is a somewhat limited benefit, but it was never our intention to exclude any population from eligibility for that benefit. And we have been working with your staff and others to clarify our intent in that regard.

The CHAIRMAN. I think others will come back to the issue.

Since my time is running out, let me ask about the concern regarding the personnel training to work with people with mental retardation or other developmental disabilities. Some of the witnesses have made the point that physicians and other health professionals have not historically received the training they need in professional schools to meet the health needs of people with mental retardation and other developmental disabilities.

Can you comment on the need for such training, and do you have suggestions for us about how we can address this in terms of

health care reform?

Ms. FEDER. I think you are well aware, and we have worked with you in general on this issue, that we are concerned that we need to reshape the nature of our health professionals and their training in a number of ways. We have placed considerable emphasis on greater training of primary care practitioners in which this kind of education may indeed play a critical part as it might be for all kinds of health professionals.

I think what I can say is that we are committed to improving the capacity of our health professional work force to address everyone's needs and would continue to work with you on the best way to do

that.

The CHAIRMAN. Well, we hope you will. We find that medical schools do not want to take suggestions and that it will take some incentives to move in these directions. This is very important. In the past, medical schools did not take our efforts lightly, support from the administration for a comprehensive approach is needed as we move in these directions. We want to work closely with you, and to the extent that this legislation can reflect the best judgment in moving us there, we are certainly strongly committed to doing so.

My time is up. Senator Durenberger?

Senator DURENBERGER. Thank you, Mr. Chairman.

Judy, welcome. Let me also say, Mr. Chairman, that I see your sister Eunice in the audience, and although she has been to so many of your birthday party, I am sure she is not here for the birthday party. But let me just say to Mrs. Shriver that last week, I was in Puerto Rico and went for a walk in San Juan and ended up in a stadium and found myself sitting down and spending a good part of the rest of the day in the stadium because they were doing their Special Olympics in San Juan. And I must say the excitement and the opportunity that you give us in Minnesota a couple of summers ago to enjoy the incredible abilities of people with disabilities—it just never goes away, and it is one of those wonderful, wonderful contributions that you and your family and everybody has made to the lives of people all over the world.

Judy, I am going to try to ask you a question that may come out imprecise, but you and I have known each other long enough to

know that that is usually the way we relate.

Ms. FEDER. I will try not to respond in kind. [Laughter.]

Senator DURENBERGER. Very good. As the chairman has already indicated, we had the pleasure, a number of us, of getting to know each other through the work of the Pepper Commission, relating to long-term care and acute care, and the whole issue of access to services and so forth is really important.

Listening to your statement and reading through your statement, it indicates that the administration wants to make sure that the widest possible variety of services are available in all the communities in this country to meet all of the needs of everyone. And that

is the foundation for my question.

Traditionally, as we define needs, we then look to communities to see what kinds of services best meet those needs. Then we convert those in one way or another at this level, usually, into some kind of a program or a guarantee or a mandate in an existing program, to make sure that this newly recognized need is met with these newly available, newly recognized, newly discovered services.

And as I listened to your statement and as I read through your statement, the question I want to ask you deals with the issue of accountability. The way we have been doing accountability, do we have the services that are necessary to meet the needs that are

there?

The way we have been doing accountability in the past is usually through the reimbursement system, because a lot of people cannot afford these so they need a third-party system, and it usually ends up being a public system of some time. So we set up a prescriptive kind of a system, and we struggle from person to person and from day to day and from year to year and from Congress to Congress,

in determining how accountable are these particular service

deliverers to this system.

One of the reasons why I am attracted to getting the dysfunction out of the current market, one of the reasons why I am attracted to accountable health plans, is that accountability is down there at the community level, and the accountability is there between the service provider and the consumer, and as needs change, the services change, and as service providers become less responsive and less responsive, there is someone else there to be more responsive. You can only do that at a community level.

So I need to have you help me understand how the President's program is going to move us from the current system of accountability to a new, community-based, through an accountable health

plan, system of accountability.

Ms. FEDER. Senator, I think you were very clear and very precise, and I think the President shares your objective and belief as to how accountability is best promoted and how quality is best improved, not with micro regulation, but with a continuous system of information and of choice that promotes a continuing improvement

in the quality of care.

The way in which the President's plan would achieve that movement has several steps. First, you must have everybody covered. You essentially have to have that arrangements so that there is no more shifting of cost from one to the other, no more capacity to avoid high-risk populations, and essentially a sharing of spreading of risk so that we reestablish the true community that insurance is intended to be.

We also, then, need to give everybody a real choice of health plans that essentially, not only are we creating offerings for everyone, but we make sure that all of us have access to those offerings, ideally, in an open, public place, so that insurers cannot selectively choose where to market and avoid difficult populations. So that is

another very important feature.

We also emphasize very heavily family and individual choice, so that it is not our employers who are choosing the health plans; it is we as individuals and families who are choosing our health plans.

And we have an incentive to choose a plan that provides value for the dollar because we pay the difference between the contribu-

tion that our employer makes and the cost of a plan.

And finally, we hold all the plans accountable for delivering the guaranteed package, and we must have that common package again in order to enable a fair, informed comparison across plans in order to make those choices meaningful.

Senator DURENBERGER. I really appreciate the precision of your response, and I would like to explore each one of those four, but I will not because I want to ask you one other question, and I have only a minute or so remaining, and that is around the issue of ben-

efit design.

Currently, the major difference between the President's proposal—I call it the 58 pages of fairly specific sets of services—and the one that is in the Breaux-Durenberger bill, in which we probably have five or six pages, and it is almost a generic description of benefits rather than a specific service in terms of prevention, diagnostic, therapeutic, rehabilitative, and so forth. And then we leave to the process, and particularly to each accountable health plan, deciding exactly what service is most appropriate for the consumers or the members of particular health plans. And I do not want to debate that issue, but if you have an observation, this is so difficult because people tend to think in terms of services, and every special group wants to find out whether their service is described in this national plan. From my standpoint, the ideal is that the specific services and the way in which they are delivered is going to be in your accountable health plan; it is not going to be in the national legislation. But the national legislation is the framework, the framework guarantee, that some set of services which may change from time to time and be suited to particular people will change.

Can you just briefly discuss that?

Ms. Feder. Senator, when we approached this, what we felt was critical was providing a specificity about the scope of services that people can expect to have and that plans can be expected to provide. The level of precision that we have provided is in order to truly address the security concerns of the American public in terms of knowing what they can expect, comparing it to what they have today and assessing that they really will achieve security. We feel that one needs a level of specificity and precision to achieve that.

that one needs a level of specificity and precision to achieve that. But essentially, what we have left to plans' discretion is how they provide those services. We have not identified the specific types of providers that plans must use. It is their choice, based on the licensed providers in a State, to put together the best mix of services, to determine in a relationship between practitioners and consumers what are the most appropriate services at a given point in time. So we believe that we have provided the kind of flexibility that you are talking about, but with an underlying guarantee to consumers that the full range of services they expect to have covered will be covered.

Senator DURENBERGER. Yes. The bottom line on this, Mr. Chairman—and this is such a critical issue, because we have a tendency—and this community knows it—to overpromise and then underdeliver when you get to the specifics. On the other hand, the estimators at CBO sit there, and they go through all of your 58

pages, and they assign huge amounts of money to it.

I do not have an answer to this, but I think it is a very, very critical part of our coming together on a proposal so that we can guarantee that comprehensive set of benefits without getting too prescriptive in the way in which we deal with specific services.

prescriptive in the way in which we deal with specific services.

Ms. FEDER. I would just add that essentially, when you look at what we have guaranteed, the Congressional Budget Office did confirm that we can achieve universal coverage and spend less money in almost the near term than we do today. They have confirmed that the President's approach is achievable. And we believe that the best approach to fiscal responsibility is to be very clear about what benefits we are guaranteeing up front, rather than to leave them to determination after enactment. So that is the approach we have taken.

Senator DURENBERGER. Thank you.

Ms. FEDER. Mr. Chairman, could I just make one more comment?

The CHAIRMAN. Yes.

Ms. FEDER. I know we have been focusing on the guaranteed package, but it seems to me that an observation with respect to a long-term care proposal is relevant to the concerns that you raise, because if you look to the way in which we have designed that proposal, we have left flexibility not only to States, but in programs, to tailor services to people's specific needs and circumstances rather than to take a prescriptive approach, and I think that that is quite consistent with the concerns that you raise.

Senator DURENBERGER. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Harkin?

Senator HARKIN. Thank you, Mr. Chairman.

Again, I applaud the administration for your commitment to universal coverage. I had this chart prepared—and I cannot read it from here, but we have reproduced the chart on individual pieces of paper—that shows the positive aspects that are critical to the disability community.

I also want to point out that the bill makes every entity under it subject to both ADA and Section 504, which I most heartly ap-

prove of, and I am glad you did that.

I think as we go down the road in this health care debate—and I say this to my good friend Dave Durenberger from Minnesota—as we go down this road, we have worked together very closely on ADA. There were a lot of compromises to be made; I remember a lot of meetings that Chairman Kennedy was involved in in hammering out these compromises. And that is the nature of this business, and I understand that, but I think that even as we went through the ADA, there were certain fundamental principles that we did not compromise. We may have compromised on how to get to those end goals; that is always subject to debate and the best expertise that we can muster up here. But I think on the terms of some of the basic fundamentals that you talked about in terms of universal coverage, portability, not excluding any population, preexisting conditions, I think we just cannot compromise on those, and we are going to have to figure out how we can meet those and keep faith with ADA. We have to keep faith with it. We cannot say, well, we will pass some bill, but it does not correspond to ADA; we just cannot do that. And I am sure that we can work that out.

On the issue of the gatekeeper, it is always a perplexing problem, especially in the managed care situation. I understand what you are saying about the fact that gatekeepers will try to keep costs down and services high. Yet, they look at the cost savings, and the cost savings may be in the next year, because obviously they do not want people leaving the plan in the next year when the next open season comes around, so they look at the cost savings that year. They may not look at the cost savings down the pike, so there may be an expenditure of money that year, and they may say, "We cannot do that because we want to keep this down," even though it may lead to some cost savings 3 to 5 years down the pike. That

is again a concern that we have to keep in mind.

On the issue of congenital disabilities, let us take three instances of three infants. The first infant is born with cerebral palsy. The second infant is injured during the birthing process and develops

cerebral palsy. The third infant, within an hour after birth, develops meningitis and as a result develops cerebral palsy. In other words, one infant has a congenital disability; the second suffered an injury that resulted in a disability; and the third developed an illness that resulted in a disability. All three infants have identical needs for outpatient rehab services, home health care, and ex-

Your statement that you never intended to exclude any population is I think right to the point on that, and I hope that we can

work together to assure an equitable result in this matter.

Ms. FEDER. We intend to, Senator Harkin.

Senator HARKIN. I appreciate that.

On the accountability issue, I have a little bit different approach than Dave had on this. If you have a plan out there, and you get these comparative reports, let us say the plan gets an "A" rating for meeting the needs of the average patient. Well, what about individuals with disabilities or chronic illnesses? Will these report cards and other instruments also assess that extent? In other words, what if they got an "A" for the average patient but got an "F" for those with significant disabilities? How do we judge that? I assume that you are going to be working that out, and I would like to work with you on that.

Ms. FEDER. Absolutely. We have always looked at the quality performance report as a way to gain information particularly on treatment of vulnerable populations and intend that it be used in

that way.

The CHAIRMAN. Senator Harkin, would you yield on that point?

Senator HARKIN. Sure.

The CHAIRMAN. What do they do in Pennsylvania, for example? Do they address these issues in terms of the information campaign? Do any of the States now, the few of them that do have informational material, address specifically disabilities?

Ms. FEDER. I would have to doublecheck, Senator.

The CHAIRMAN. Could you submit that, perhaps, if you would?

Ms. FEDER. Yes. One of the things that we have been building on is the experience of plans themselves that have been investing considerably in improving the information available on perform-

The CHAIRMAN. But if you could show us which States are doing

it well and so on. Thank you.

Ms. FEDER. Yes.

Senator HARKIN. That is a good point. I would like to know that,

I would also like to know if any of these States have advisory panels set up with members of the disability community, parents, others in the disability community, to perhaps advise. We may want to look at that in terms of the national board having that kind of input. I would like to again work with you on that.

Ms. FEDER. We can do that, yes. Senator HARKIN. Finally, I am pleased to see that you have included this program for children with special needs that will preserve the wraparound services.

Ms. FEDER. That is correct.

Senator HARKIN. That is most important, most important. I am talking now about the Medicaid wraparound services, the early and periodic screening, diagnostic and treatment services or EPSDT. This is an essential element of financing for early intervention services under Part H of IDEA. If these wraparound services are not covered for these children, it will raise questions as to whether the early intervention program which is just now beginning to fulfill its promise for infants and toddlers with disabilities will remain fiscally viable.

Both Part H and EPSDT are based on a premise that it is particularly cost-effective to provide comprehensive preventive services to children from birth. And again, we get into this thing about do you save the money in the first year. Probably not. Cost could go up. But it is the savings we get further on down the road which

we know about and can understand.

So again, I look forward to working with you to preserve these comprehensive services that we have now and to make sure they are part of these wraparound services that families with children with disabilities engaging in Part H services can continue to receive under whatever program we come up with here, which I hope is close to the President's program, obviously.

Ms. FEDER. We appreciate your concern, Senator, and look forward to continuing working with you to preserve those protections.

Senator HARKIN. Thank you. I just wanted to make that point for the record.

Thank you, Mr. Chairman. The CHAIRMAN. Thank you.

Dr. Feder, I would like to pursue some information about the last census report, which gave us some disturbing news. I believe our goal should be, where reasonably possible, to provide training and services to individuals with severe disabilities so they can be gainfully employed and have a quality of life.

Under the census, it showed that only—I believe he said 48 percent not 18 percent—of people with severe disabilities were covered by private insurance, whereas 80 percent are otherwise covered for

health care and training, and so on.

Do you know why that is? Was it that the families had refused

coverage? Do you know why that figure is so low?

Ms. FEDER. Well, I think there are a number of factors, Senator. First of all, several of us have made comments about the difficulties of those with disabilities to obtain or retain coverage; but I think there are a number of other factors here as well. Significant numbers of people with disabilities also have relatively low incomes, and that creates a problem. If they are not working, coverage is not available to them. It is one reason that simply reforming the insurance market is not going to guarantee people coverage. We have to have a more comprehensive reform than that.

It is also true that people with disabilities are more likely to be receiving Medicaid or Medicare coverage than other populations be-

cause that is one of the criteria for eligibility.

Let me pursue as to what difference it is to an individual if he is presently covered under private insurance as far as his access to the kind of training and services he needs. Would the Clinton plan

improve upon what is presently available in the private sector, or

are there gaps in that respect?

Ms. FEDER. I would say there are enormous gaps in that respect. First of all, we know that private insurance plans today tend to have lifetime limits on benefits, and that people with disabilities are likely to exhaust those limits. That means your coverage is

gone.

I think one of the most poignant things about disabilities is that although we sometimes speak as if we are different communities, people with disabilities and people without, we are all at risk of a disability at any moment. I think "temporarily abled" is the way the disabled community often speaks about others, and I think that we should be cognizant of the fact and know that in the current insurance marketplace that any of us who becomes disabled or develops a disability is at risk of losing the protection we have at any given time because of the way the insurance marketplace operates today.

In terms of the guaranteed benefits, we are offering a comprehensive scope of benefits. It is about consistent with the average plan today in terms of the protection it provides. It is a good, strong, solid protection that provides not only the hospital physician and prescription drug coverage that we all need and many people with disabilities particularly need, but in other respects in-

cludes preventive coverage for all populations.

Senator JEFFORDS. Is the present coverage under the private sector sufficient, if you made it universal, to take care of most of the problems, or are we going to need additional services available to ensure that the disabled can reach the goal of either gainful em-

ployment or quality of life?

Ms. Feder. Well, I think that essentially what we have to do is, as we were discussing earlier, agree upon a guaranteed package of benefits. I think that that assists people with disabilities far better than much insurance does today. But I think that the need for further protections for vulnerable populations continues. That is why we have a long-term care component of our plan. Insurance today does not include for the most part help with basic tasks of daily living that people with disabilities require. We feel that those needs are as substantial as any other needs that people face, and people do not distinguish whether it is a doctor they can afford or an assistant to help them get out of bed in the morning.

So we feel that addressing those additional needs is part and parcel of comprehensive reform, and that is why we have included an additional program which is not a part of a guaranteed benefit

package and is not a part of insurance today.

Senator JEFFORDS. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Wellstone?

Senator WELLSTONE. Thank you, Mr. Chairman.

I think what I will do, Dr. Feder, is just list some of the concerns that came up with my meeting in Minnesota and then maybe have you respond to them. I will not do them one by one; I will just list them all, and then you can just respond, and that will save us time.

The only general comment I wanted to make related to the question that Senator Kennedy asked you earlier about gatekeeping, and I think Senator Harkin also spoke about that as well. I listened very carefully to your response, and out of total mutual respect, I have to tell you I am still not persuaded. That is to say, I really worry about these accountable health care plans and the

mergers that I am seeing.

Take my State of Minnesota. We now have three major HMOs. It is unbelievable consolidation. And Mr. Chairman, I am sure this has happened with you, too, when I talk to different populations—I will just take the disabilities community—they are really worried that when you have these networks competing to keep costs down, not so much in terms of what the package of benefits is, but whom they market to and where they locate and how they deal with people, that there is enormous potential for abuse.

And I have to say that if we have a lot of opting out and selfinsured plans, that problem becomes magnified, because we do not know what the hiring decisions and firing decisions are based on, and we do not know how any of that gets regulated, except to create some kind of huge bureaucracy, which supposedly we are trying

not to create.

But I have to tell you that I do not see this market moving. I see us moving toward oligopolistic medicine. When I read the Wall Street Journal and the New York Times, and I see the mergers that are taking place and whom the folks are who are going into this market and buying up these plans, it makes me worry that this could become monopoly medicine, bottom line medicine, and I think it could very well leave some populations—and I will just talk about the disabilities community—very much at risk. I know the theory, but I am not at all persuaded it is going to work. I just have to say that, and I will let you respond in a moment if you want to, but I just want to express that concern.

And it is amazing, because in Minnesota, the people who work in the community health care clinics, the people in public health are deathly afraid of what is going to happen to them when these health care networks are set up. They do not know where they fit in. I am talking about Minnesota, which is often talked about as

a State where we have managed care of the future.

I met with a wonderful clinic called TAMS, Teenage Medical Services. They do incredible work in the city. They have built up over a decade plus credibility with young people who come there; it is the family doctor. And no one could say these doctors and nurses are in this for the big money. But they are very worried about where this managed competition framework is going to leave

them, and I just want to express that.

Here are the specific points that were raised. One, the new home and community-based services proposal in the President's plan for persons with severe functional limitations has an extremely flawed coinsurance and cost-sharing mechanism. The proposed new program would require recipients to pay within their income bracket based on the services that they use. Requiring families who have children with severe disabilities or adults with chronic illnesses or severe disabilities to pay based on the services they need is dis-

criminatory, and then they cost this out. I cannot give you an ex-

ample, but I think you know what I mean.

Second—and Senator Harkin and Senator Kennedy also talked about this—is the limitations on those people who have congenital

disabilities, and you have responded to that.

Third, copayments for poor and near-poor families. We are concerned that the copayments required in the President's plan even of families receiving AFDC or SSI will work an extreme hardship on persons with chronic illness and disability. And they cost that

out and give an example of what it would be per month.

Then, finally—and if you want me to give you specific figures, I can, if that will be helpful; I will ask you in a moment if you want me to do so—the concern of people I met within the disabilities community is that there are in the President's plan incentives that still stack the deck toward institutional care as opposed to people being able to live at home in as near normal circumstances as possible, with dignity. And one example they give is that the President's plan allows persons needing services in a nursing home to retain up to \$12,000 in assets but does not allow the same asset amount for those receiving alternative services in the community under a home or community-based waiver program.

Now, let me just say, Dr. Feder, that I am learning, and so perhaps this sort of report may not be accurate, but these are people whom I very much respect, and I wonder if you could respond to this. So the general thrust of it—and as they priced this out on some of the copays and deductibles, it looks like there is a serious

problem, but let me hear from you about it.

Ms. FEDER. OK. Let me go back, if I could, to the first comment you made about your concern about managed competition, because I think the particular concerns that you are raising may have a great deal more to do with what is going on in the current insurance marketplace in which we do not have universal coverage; even Minnesota has not provided universal coverage—

Senator Wellstone. That is correct.

Ms. Feder.—and in which we do not have a broader framework for reform. So whether it comes to people with disabilities and providing them protections or providing the protections for those providers who have been traditionally and effectively serving those populations, I would argue that we have a different set of protections built into the plan, and I would call your attention in particular to the assistance we would provide to traditional providers of these services to form networks to enable them to consolidate—we have provided also additional protections in terms of making them essential providers—but also, assistance to enable them to effectively operate in the environment that we are talking about for reform.

So I would like to work with you further in terms of looking at

those particular protections.

Senator Wellstone. OK. We will work together further on it.

Thank you.

Ms. FEDER. Now, on the long-term care issues and the coinsurance in long-term care, we have a coinsurance provision because we are providing services to people; we want to involve them in some

responsibility for the services they use. I would need to look at your particular numbers, and I would like to see them and respond.

Senator Wellstone. I think the point is the family has the same income, but then—let me just give you an example. The Clinton home and community services cost-sharing based on severe disability would result in two families—I will do it like Senator Harkin gave his examples—each with incomes of \$1,000 per month paying very different amounts for health care which was based upon the needs of their respective children.

For example, a family with an income of \$1,000 per month and \$300 in monthly health service costs would pay \$30 out-of-pocket. A second family with an income of \$1,000 per month, but with \$3,000 in monthly long-term services—again through no fault of

their own, as you said—would pay \$300.

So the point is that that does not seem fair. It is not based upon

income but upon the severity of the disability of the child.

Ms. FEDER. What I think underlies the question you have asked is that coinsurance in the long-term care program does vary with income, but it does not reflect differences in needs. That is correct. And when we use coinsurance as a part of involving people in responsibility for their medical bills, it is true that the more you use, the more you spend.

But I think as you look at this proposal, and you look at its protections relative to those available today, which are virtually nil, for all families we will, if we enact this proposal, dramatically improve the protections that all people have. I think that is a very

important consideration.

The second issue you raised was with copayments in terms of the guaranteed package. There has been a lot of discussion about those copayments. You will recall that we have in the President's plan said that people on AFDC or receiving supplemental security income would pay essentially one-fifth of the cost-sharing in the low-cost plan that others would be expected to pay. So that is essentially \$2 per visit or \$1 for prescription drugs. It is our view that that is a nominal copayment that is consistent with everyone having some responsibility for the cost of their services.

Senator Wellstone. My time is running out, but my concern is that when you are talking about the disabilities community, sometimes there is the need to see a doctor at any number of different times, and that actually, that can add up to a significant amount of money per month based upon income, to the point where you are

going to undercut what we are trying to accomplish.

Ms. FEDER. I hear your concern, and the point is well-taken. I think what we have to do is look at the combination of require-

ments there and the limits on out-of-pocket spending.

And then finally, I wanted to address the concern with respect to a potential bias in favor of institutions, which I truly do not see in this plan. And the clarification that I would like to offer you is that the home and community-based services that we are committed to in this plan are offered without regard to income. So spenddown is not an issue for these services. I think that is very important.

Senator Wellstone. That is helpful. Thank you.

The CHAIRMAN. I think what I hear from my good friend out there is that under single-payer, the copays are really not out there in terms of maximizing utilization of these needed services. I think we hear that, and it has a very appealing ring particularly when you are talking about the kinds of things that we have been talking about here today.

So we want to work with you. I think you have a pretty good sense about some of the areas of concern, and there will be other

questions that will come.

In conclusion, I think it is important to try to put this into perspective. There are some very, very important areas and needs that have just been touched on by members here on both sides of the aisle, and I am not interested in having a bashing session, but I think it is important to put out where we are on some of the other programs just so that we have got some broad parameters. If you could just outline that in a rather detached way, if you can do that—I do not know whether we will be detached as we move further down the road—but just in terms of this discussion and debate, I think it is important in terms of the concerns that you would have as somebody who has given a good deal of thought in regard to the disabilities movement and what your concerns would be.

Ms. Feder. Well, first, I would say that if you compare the President's plan to others, I would first and foremost emphasize the universality of coverage. As you know, Mr. Chairman, we have looked at options over the years, we together have looked at mechanisms, too, that would improve the availability of coverage and have continually come to the conclusion that only if we guarantee that everybody is covered can we protect all Americans. And I would say people with disabilities are at greatest risk in a haphazard system.

So I think that that is a critical point that we must address.

Also, I would say, when it comes to addressing the needs of this population, the long-term care component of this plan is a critical element. With the exception of single-payer, the other plans do not address the long-term care needs of our citizens, and I would argue

that that is a significant failing in those proposals.

The CHAIRMAN. You have been very gentle here in your comments. We appreciate it, and we will have other questions for you. These are very important areas that we want to continue to work with you on.

Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, if I could just make a brief comment, and this is particularly true for those of us who are the proponents of other plans. I am not speaking for anyone other than myself, and I think universality is important however it is expressed. I thought the expression of it in the State of the Union was probably better than just using the words "universal coverage," because that is basically confusing.

So I don't think that is the difference. The difference will come and will be resolved, of course, here in how we can guarantee that and how we deal with the public subsidies and how much of the savings get captured in one way or another and used for public

subsidies.

And on the long-term care issue, I think most of us are ready to deal with long-term care in some more appropriate fashion than we have before. So I do not see either of those two issues being impediments between the President's proposal and at least the two that I am involved in. I cannot speak for the people to my right on this particular issue, but I can speak for those of us in the bipartisan middle.

Thank you, Mr. Chairman. The CHAIRMAN. Thank you.

We thank you very much. We will be keeping in contact with

you, and appreciate very much your presence here today.

Ms. FEDER. Thank you, Mr. Chairman.

The CHAIRMAN. We are now pleased to be able to hear directly from individuals and families with disabilities and those with chronic conditions. We believe it is through their experience and insight that we can begin to understand the inequities in our current health care system for people who need care the most, and we are grateful to all of them for being willing to testify. We are equally inspired by your strength.

We will hear first from Harry Johnson, Jr., a resident of one of our neighboring cities, Baltimore, MD. Harry has been living with AIDS for the past 2 years. His story highlights the need for a change in our current system. Mr. Johnson, we are pleased that

you could be with us here this morning.

We will also be joined by Marilyn and Tom Weisner and their son Thaddeus, from Aurora, IL. Thaddeus was born with cerebral palsy, and Marilyn will be testifying before us today about the special needs of children with congenital conditions. Marilyn is a founding member of a statewide volunteer organization advocating

for children with special needs.

We will be hearing next from Sandra Sulfaro, a registered nurse working in the emergency department at Marlboro Hospital in Massachusetts. Ms. Sulfaro was diagnosed with multiple sclerosis in 1987. She is an active member of the Massachusetts MS Society and participated recently in our New England Summit on Health Care Reform with Mrs. Clinton. We are very grateful to her for coming back again.

Our final witness on this panel will be Julianne O'Connell Beckett from Cedar Rapids, IA. Ms. Beckett is a co-chair of Family Voices and the mother of Katie Beckett. It was because of Katie Beckett's condition that Federal Medicaid waiver known as the "Katie Beckett waiver" is available for families to care for children

at home rather than in an institution.

I want to mention to all of you that we know it is extremely difficult to share these personal life experiences with all of us here on this committee, the members of the Senate, and the American people. I think all of us are very private people, and perhaps most private with regard to our health needs. It takes a good deal of personal strength and courage to be able to testify in front of the U.S. Senate. As I have said many times before, and believe very deeply, the best way we can thank you is by passing the bill. And we are going to make every effort to do that, and I am confident we will.

So we thank all of you very much for being here, and we will

start off with Harry Johnson.

STATEMENTS OF HARRY JOHNSON, JR., BALTIMORE, MD; MARILYN AND TOM WEISNER, WITH SON THADDEUS, AU-RORA, IL; JULIANNE O'CONNELL BECKETT WITH DAUGHTER KATIE, CO-DIRECTOR, FAMILY VOICES, CEDAR RAPIDS, IA; AND SANDRA SULFARO, MARLBORO, MA

Mr. JOHNSON. Senator Kennedy and members of the committee, my name is Harry Johnson, and I am here today because of my

chronic medical condition. I have AIDS.

My experience with the health care system has been extremely difficult. There are many other people in this country who have worked all their lives who are dying and do not have any health care. I ask you to help us by passing legislation that will provide affordable health care to all people.

I started working as a forklift operator at Monroe Foods in Baltimore City in 1983. At Monroe Foods, the employees get health care through a health and welfare fund. Every month, money was taken from our paychecks, and the company made a contribution to the health fund to pay for our health coverage.

My doctors were at the University of Maryland Medical System. When I was sick, all I had to do was call up my doctor and go see him. After I went to the doctor, I would submit claim forms for

medical benefits.

I first found out I was HIV-positive in May of 1992. This came as a shock because I was feeling healthy and did not have any symptoms of the disease. The doctor only discovered that I was in-

fected when routine blood work came back HIV-positive.

When I found out I was HIV-positive, I thought I was going to die right away. But as I became more educated about the illness, I became less fearful. I decided to go on with my life. In some ways, I was lucky. The health care I received at the University of Maryland when I first found out that I was infected was excellent. I was given counseling and medication. Because I was still healthy, I returned to work.

After about 8 months, I lost so much weight that my doctor told me to stop working. My doctor told me that my drastic weight loss—what he called "wasting"—indicted that I had fullblown

The forms that I filled out to get sick pay were signed by my doctor and said that I had AIDS. My claim for sick pay was rejected. This had never happened to me before. And although the health fund had always paid for my medical care before I developed AIDS, I was now told that I could not get medical benefits for AIDS. I was told that the health plan did not cover AIDS, and all my claims for doctor bills, hospital bills, and soon thereafter, medication, were cut off.

I was devastated. If I had any other illness, I would have been covered under the health plan, but because I got AIDS, I was left without any medical coverage. After I had paid money, and quite a bit, all these years for medical benefits, I was told that I could

not get anything in return.

I did not know what I would do. At the time in my life when I needed the most medical attention and medication, I was cut off. I was abandoned, left to find whatever I could and pay for it myself.

I could not pay for health care costs on my own. I did not qualify for public health insurance. I did not start getting disability pay from the Government for several months, and when I did start receiving disability pay, it was around \$850 a month and was only enough to pay for my rent, food, and some over-the-counter prescriptions. There was not enough money leftover to pay for my medical bills.

Unlike most patients in this situation, I have a good social worker at the University of Maryland who does not charge me and is extremely helpful. She convinced my doctors to continue to see me. But when they found out I no longer had health insurance, I could no longer expect to get treated right way. I never knew whether

I was going to be able to get medication or not.

The constant stress of worrying about my health care took its toll on me. I could not eat. I lost so much weight that I could not lift myself out of bed. I was weak, and sometimes I would fall to the floor, where I would have to lie until I got the strength to pull myself up.

My life is filled with uncertainty. I never know if my next prescription will be filled. I fear that the doctor will stop seeing me.

There is not a day that goes by that I do not feel this panic.

I understand my disease, and I know that living a stressful life wears down my immune system. I believe that that is why I have deteriorated so rapidly. But I live in the real world, and I know that I need medication and health care to survive. As a result the continuous stress I live with will not go away.

I urge you to help people get the care they need. It seems unfair to me; if you pay for health insurance all your life, it should be there for you when you get sick. I never could imagine how else this should be. I cannot understand why some illnesses are paid

for, and others are not. If you are sick, you are sick.

Also, people who change jobs or are laid off should be assured that there is some type of health coverage available to them. Becoming infected with HIV and developing AIDS is a tragedy. It is equally tragic that many people infected with this and other terminal illnesses have to face the uncertainty of living without health insurance. No person with a terminal illness should be abandoned and left in fear about whether they can get the medication they need to stay alive.

All we are asking for is a little security and dignity in life. I ask you to adopt legislation that will ensure health care coverage for

all.

Thank you.

The CHAIRMAN. Thank you very much, Mr. Johnson. We appre-

ciate it, and I will come back to some questions.

I see the Weisner family here, and I know young Thaddeus is ready to speak up a little bit. You have been extraordinarily patient, and I think we may go ahead with your testimony now and then, if you want to take a short break, obviously we will respect that.

We are very grateful to you. Thaddeus is doing very well here,

and we want to thank the family for joining with us.

I would be glad to recognize you now, Mrs. Weisner.

Mrs. WEISNER. Thank you, Senator.

Good morning to all the Senators. I am Marilyn Hogan Weisner, and you have already met my husband Tom and my son Thaddeus. I would like to begin by thanking you for inviting me to speak at this hearing today and participate in the health care debate.

I am grateful for the opportunity to talk to you about the medical service that are crucial to the health and well-being of congenitally

disabled children.

Thaddeus is the one who prompts me to be here today. He is 9 years old, and he has cerebral palsy. He has spasticity, rigidity and quadriplegia, which means that all of his muscles are extremely tight and difficult to move, and that all four of his extremities are

involved in his disability.

Thaddeus was born in the Solomon Islands while my husband and I were in the Peace Corps. He had a difficult birth, did not breath quickly enough, and suffered damage to his brain. He immediately had many problems. He could not nurse or suck on a battle. His nervous system was so traumatized that he could not speak for more than a couple of hours at a time and would often be up the entire night and day. He suffered various repeated infections, and he had a serious delay in his motor development.

He reached none of the milestones of normally developing children, with the exception of one. On the day he turned 8 weeks, he woke up with a smile, achieving that milestone just in time. I think on that day, his Dad and I were able to smile for the first time in

8 weeks, too.

The three doctors available to us when Thad was born were general pediatricians from Britain and Canada with no special training in children's disabilities. In answer to my repeated questions about what was wrong with my son and what we could do to help him, I repeatedly heard that there was nothing we could do for him. In fact, they suggested that we stop trying so hard to do some-

thing and just accept things the way they were.

When Thaddeus was 9 months old, we brought him back to the States. The first doctor we saw spent a total of 5 minutes with Thad before deciding that he had no intelligence. He said that Thad would have a lot of respiratory infections such as pneumonia, and that if we were not very vigilant, we could be rid of him sooner. We rejected both his assessment and his recommendation, and we sought the opinion of another specialist who correctly diagnosed Thad with cerebral palsy and referred us for the proper treatment.

Thaddeus began to receive physical therapy to relax his tight muscles and help him learn to sit and to walk, and occupational therapy to help him learn to use his arms and his hands, and speech therapy, to teach him how to eat and help him find a way

to communicate.

He was referred to an orthopedic surgeon to ensure that he did not develop contractures, which are severe shortening of the mus-

cles and dislocations.

We are thankful that our insurance company allowed us to seek a second opinion and begin treatment for Thad while he was still so young. Without this early diagnosis, without the physical, occupational and speech therapy, and without the specialist consultations that he has received, Thad's body would be restricted by contractures. He would suffer hip and shoulder dislocations. He would require repeated painful surgeries in order to overcome, but never fully correct, these problems. He would have progressing scoliosis, which would eventually impinge on his internal organs, causing damage to those organs. He would never have learned to suckle and later to chew and swallow solids. More than likely, he would have had a tube surgically implanted in his stomach where we could pour in tasteless nutrients in order to sustain him.

Instead, because of the therapy services and the specialist consultations that Thad has received over the past 8 years, he has made tremendous progress in his development. Every year, he can

do a little more.

Two years ago, Thaddeus took his first steps. Last November, with the help of his big brother, he walked down the aisle as ringbearer at my sister's wedding. That was a feat of immense proportions for him, and the look of delight and pride on his face was

worth a million dollars.

Thad is beginning to grasp an object with his hands, giving him the potential to feed himself and get around with an electric wheelchair. He is using his eyes to communicate by looking at a word or a picture to answer a question or indicate a choice he would like to make. He is currently enrolled in a regular first grade classroom where he is learning reading and math. And he is beginning to work on a computer that he can operate by just looking at the choices presented on the screen.

Because of the physical, occupational and speech therapy that Thad has had and the specialist services, I can now anticipate the day when he will become a functioning, productive adult who can contribute to his own support and hopefully never live in an insti-

tution.

Thad's progress has not been as seemingly miraculous as that of Christy Brown, whose life was portrayed in "My Left Foot." In fact, the success of disabled children is not a miracle at all. For Thad, as for others, it has taken years of work regular visits to specialists, weeks and months of therapy, and hundreds of minute victories to bring Thad to the threshold of communication, mobility, and function.

It does not take any special training to see the difference between a child like Thad, who has received appropriate medical services at an early age and had a continuation of those services, and a child who has not. The sad story of another boy I know with

cerebral palsy illustrates this.

Try to picture Alex, whose disability is similar to my son's, but who did not have insurance coverage and did not have the needed therapy and specialist services. His arms and his shoulders are contracted. His fingers are severely deformed. He cannot bend his hips to sit up straight. His hips are twisted as the result of a dislocation which was corrected or treated by surgery and a metal plate. And his head is nearly permanently thrown backward. When he does get his head forward, he cannot stay that way for long, because his skeletal structure has changed, and he can no longer swallow easily with his head forward.

These deformities make Alex nonfunctional in spite of the fact that he has shown the potential and the desire for communication and interaction. He will undoubtedly undergo many expensive surgeries, not to improve his condition so much as to slow the effects of these contractures. His mother is very loving and does everything she can for him, but at some point she may find it necessary

to put him in an institution.

It also does not take any special training to understand why it was and is so important for Thad to have his care directed by specialists who understand his disability. It is the specialists who are trained to determine what the disorder is, what treatment is appropriate, what problems to anticipate, and what new discoveries are

made that can help our children.

Parents of special needs children recognize that the movement in this country by insurance companies with or without reform is toward the HMO as a preferred method of health care delivery. But we also know that many HMOs have not been as effective in cutting health care costs through efficiency as they have been through cutting benefits. And the benefits they most often cut are the benefits for the very services that special needs children need most.

Many HMOs are unwilling to allow referrals to specialists. They are unwilling to approve referrals to comprehensive diagnostic clinics at the children's hospitals, and they often refuse to approve

therapy for congenitally disabled children.

Charlie's story is a good example of how many HMOs are not responsive to the medical needs of special needs children. Charlie was born prematurely with hypoglycemia from his mother's diabetes, at a respected children's hospital in the Chicago area. He was told by the specialist there to return to the diagnostic clinic at 4 months of age and every 4 months thereafter in order to monitor his development. Charlie's primary care HMO physician would not approve the referral to the diagnostic clinic and would not even recognize that Charlie had a problem with his motor development. Possibly, he was trying to avoid the black mark that many HMOs give doctors who refer to specialists.

At 2 years of age, Charlie had still not begun walking. By chance, at a well-child checkup, the primary care physician was not there, and Charlie was seen by a new associate. He immediately noticed Charlie's tight muscles and the scissoring of his legs and realized that Charlie had cerebral palsy. He suggested that he see a pediatric neurologist immediately, and with the influence of the

second doctor, the referral was made.

Charlie was diagnosed with cerebral palsy, and to help him learn to walk, he began physical therapy under a very limited benefit. When the benefit ran out, the HMO was extremely reluctant to approve additional therapy, even though there was every reason to believe that with continued treatment, Charlie would walk independently. A battle ensued between the parents and the HMO, and eventually, additional therapy was approved. However, if the original HMO doctor had made the referral as he should have, Charlie's cerebral palsy would have been diagnosed sooner. Had his cerebral palsy been diagnosed and treated sooner as it should have, Charlie would have begun walking sooner and needed less therapy to do so. By delaying diagnosis and therapy, the HMO caused Charlie to have a more serious delay and actually caused the cost of his treatment to increase.

In conclusion, I would like to say that I am here for three purposes today. First, I am here because I believe that no congenitally disabled child should ever be denied the services that he or she needs to reach his or her potential and that universal coverage for all children is something this Nation owes itself.

I am also here to fight for Thad's future and the future of thousands of defenseless disabled children who will lose existing medical benefits for therapy and specialists unless Congress specifically

includes them in final health care legislation.

There is enough courage among these children and their parents to move mountains. Please do not take away their hope. The President has assured us that no one will lose benefits, and in fact many will gain benefits with his plan. Mrs. Clinton declared in a recent radio interview that the President's plan will provide the same coverage that is currently available to those who have, in her words, "good insurance policies." Parents of special needs children know that these "good insurance policies" do cover diagnostics for early intervention, do cover therapy, and do cover specialist consultations for congenitally disabled children.

My son receives physical, occupational, and speech therapy and specialist services right now under the health insurance that is provided by my husband's employer. If these services are not included in the national plan, my son will lose those benefits. The children whose pictures and stories I have included in my written testimony also receive these services under their parents' insurance policies. Unless these services are included in the national plan,

these children will all lose these services.

More than 1,500 children in just ten of the centers in my area alone and thousands more across this country are currently covered for these services under their existing insurance policies. Unless these services are covered in final health care legislation, these children will all lose the benefits for these services, services which are crucial to their well-being and which constitute their best

chance for a decent life.

My third purpose today is to make sure that there is access to the specialists who understand the warning signs of the multitude of disorders which afflict children at birth. We thank God that we had access to the services that we needed for our son—people who could diagnose his condition correctly and refer him for treatment. Without these, he may well be in an institution today instead of appearing before the U.S. Senate.

I am one person speaking today, but I am speaking for thousands of parents. We are asking you to defend the future of these special needs children, whose bodies may not be whole, but whose spirit and determination are incredible to behold. We are asking you to see to it that they continue to have access to the services that are

their basis for hope at a cost that can be afforded.

Can anyone in this room look me in the eye today and tell me that health care legislation which denies benefits— indeed, which excludes existing benefits to disabled children—can be called reform?

These children are your quiet constituents, Senators. Some of them cannot yet stand. We ask you to stand up for them. Some of them cannot yet grasp. We ask you to take their hands. Some of them cannot yet speak. We ask you to be their voice. The Lord said: "Whatever you do for the least of these, you do for me." Matthew, Chapter 25, Verse 40.

Thank you very much.

[The prepared statement of Mrs. Weisner may be found in the appendix.]

The CHAIRMAN. Thank you, Mrs. Weisner, for an absolutely superb presentation. We have enjoyed having Thaddeus very much.

Mrs. WEISNER. He smiled as he heard that.

The CHAIRMAN. When you mentioned it earlier, he was smiling from ear to ear.

I just want to say how impressed we are with you and your husband. All parents are devoted, obviously, to their children, but you have really been extraordinary. I think all of us are grateful and inspired by your comments and by all the good things you have done. He is a very lucky boy to have both of you, and I am sure he appreciates you.

Mrs. WEISNER. Thank you.

The CHAIRMAN. Let me just ask you a couple of questions, and then we will go ahead with the remainder of the panel. I think Thaddeus has had a full morning here, and he may want to stay on or he may not, but we will leave that up to you. Let me ask a few brief questions and then turn to my colleagues, and then we will continue.

I think you have described those essential benefits that must be included in the health reform plan for a family with a special needs child. You have referenced that in your testimony. Let me just ask you what are the benefits that are commonly left out? And what are the specific benefits that we really ought to focus on? We will obviously make an attempt to include them all, but what are the ones that you would really like to highlight?

Mrs. WEISNER. Mainly I would like to highlight the physical, occupational, and speech therapy, because that is the thing that really helps children become functional. For example, my son, as I said, his muscles are so tight. If he had not had therapy, he really would not have learned any movement at all, and he literally would be stuck in some positions that would make him absolutely nonfunctional.

That is a very preventive type of thing, because not only does it teach him how to move and become functional; it prevents further serious problems. I mentioned the surgeries. It will help him never have to be in an institution. There is just no way that we cannot

give these children the therapy they need.

Institutional care is just outrageously expensive. I have heard estimates that it can cost up to \$100,000 a year to keep someone in an institution. If we do not provide these services now, we are going to have babies in institutions, and we are going to have dependent adults later in institutions who may have become functional if they had had these services.

The CHAIRMAN. I know we are not getting into questions on the Canadian system but it may be a good lesson for our medical problems. One of the disability movement issues in the many families that have disabled children, and the attention the child requires from both the mother and the father. I can still remember the parents of a spina bifida child. The father was a construction worker who was laid off part of the time, so he would take care of the children. They had to cut back some of their income in order to take care of the child. The mother was a schoolteacher, and when she was needed at home, the system eventually worked against them. Eventually, in order to get treatment, they had to effectively bankrupt themselves and rely on a State system—care in the State system

tem was only available in institutions.

Compare this to parents in the Canadian system. I know of parents who had five children. After the children were full grown, the parents started adopting disabled children. They took them out of institutions and brought them into their home. The Canadian system paid for the health care support for those children. The parents were glad to give them love and attention and a home, and the Canadian system provided the medical treatment and assistance to keep them at home. The parents were glad to do it because they wanted to let their other children to know what love was all about. I think it is really an extraordinary system, and I do not know whether we will be able to achieve those same objectives in this program, but I am going to do everything I can to try and get there. I am sure other members will as well.

Finally, let me ask you about the HMO. You have heard the exchanges between different committee members. Do you have any specific ideas about what might be done about the problem of

HMOs and individuals with disabilities?

Mrs. Weisner. Yes, I do. One thing I think that would be very important if a parent with a special needs child chose an HMO plan is that the specialist would become their primary care physician rather than the general pediatrician, that the specialist would be the gatekeeper, because he would be the one who could determine what services were really necessary.

The other thing that I would like to see with HMOs is an assurance that it is actually medical necessity that determines whether a child needs a service. A lot of times with HMOs, it has more to do with whether they want to pay for the service, not whether the doctor has said that this service is actually medically necessary.

The CHAIRMAN. Mr. Weisner, we did not hear from you, but we want to thank you very much for being here. Is there a brief com-

ment you would like to make before I turn to my colleagues?

Mr. WEISNER. Actually, Senator, I think the other two members of the family have made themselves well-heard today, and therefore I will not say anything except thank you for allowing us to appear before you, and I hope that you will take Marilyn's words and follow through.

The CHAIRMAN. Good. Thank you.

Senator Jeffords?

Senator JEFFORDS. Thank you for very compelling testimony, Mrs. Weisner. I am curious as to how you had the luck of having a health care plan which provided the services Thaddeus needed. Did you have health insurance at the time of Thaddeus birth, and forward, or did you get insurance later?

Mrs. Weisner. Well, first of all, I really do not think, Senator, that it is "luck." There are literally thousands of children across this country who do have these services provided by their insur-

ance, and I think it was not luck. I mean, I feel very lucky because I know there are children who do not, but there are also many, many children in the same position that we are who have these

services provided.

No, we did not have it at birth. We had another policy at birth because we were overseas, and they did provide therapy coverage for my son, without limiting the number of visits that he could receive. When we came back to the States, my husband took a job, and the insurance was willing to accept my son in spite of the fact that he had cerebral palsy, and we were able to get his services

that way. And I do not think that is totally unusual.

Mr. Weisner. I would say as to the element of the pre-existing condition, we may have been lucky in that regard. But I think Marilyn's point is that there is a perception that the type of care or therapy, and so on that Thad has received under private or group insurance is not widely available, and I would say that I think it is much more widely available than people believe. Now, there is still a good percentage of children who are not covered that we would love to see covered under private or national health care, but there is in fact a good percentage of children like Thad who do receive benefits, therapy, and other services under private group insurance.

Senator JEFFORDS. Have other families in similar situations as yourself, experienced loss of health coverage when they changed jobs or did having a child with special needs prevent people from

accepting better jobs?

Mrs. Weisner. Oh, yes, that is definitely a problem. I know of several people who will not change jobs because they do not want to lose their coverage and others who, as you said, left their jobs. And some have been lucky in that they have kept the COBRA plan; they were able to keep their existing insurance and pay for it. And sometimes what I have seen with people is there is an 18-month pre-existing condition exclusion, and then after 18 months, the child who has the pre-existing condition can then get on the regular policy and be covered. So that does exist also.

So it is not that everybody who leaves his company never gets insurance coverage again. And that is something that can be determined by legislation, just like many of the other things that we are

trying to determine.

Senator JEFFORDS. Yes. That is why I favor doing something, to make sure that we do not have the problems that you have just alluded to.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Harkin?

Senator HARKIN. Thank you, Mr. Chairman.

It is good to see you again. I am glad you could make it down.

The weather is a little bit better today.

I think the questions have been asked, but I would just follow up on what Jim Jeffords just said, that we are finding in a lot of these policies that it is not just that you lose your job and you lose your policy, but they are getting so expensive that every year, they ratchet them up, and that way they are excluding people and getting people out of those policies because the costs keep going up all the time. On the point you made about the prevention of secondary disabilities, we focus a lot on prevention in this health care reform. Most people think about it in terms of cholesterol screening and mammograms and things like that, all very important, but we also must keep our attention focused on what you have described, and that is the therapies and the interventions that can prevent further disabilities down the line. And I do not think that has been adequately addressed yet, but hopefully we will as we get this bill through. But that also ought to be a very important part of prevention.

And again, it comes back to what I said earlier to Ms. Feder, and that is, when you get in a managed care situation, you have two problems. You have the gatekeeper, who may not be familiar with the particular disability that a child may have and may overlook that or may not understand it. Then you have the secondary problem of managed care trying to cut costs. They look at savings, and as I said earlier, they look at the first year because they want to keep as many people in as possible, and they look at the savings in that year rather than what comes later on. And certainly in Thaddeus' case, probably the first year savings were not any savings at all, but the savings to our society are going to accrue down the line in years to come. Somehow we are not factoring that in, and we have just got to look at that. It is so important.

Mrs. WEISNER. That is true.

Senator HARKIN. And you made that case. I am just repeating it

for emphasis, I guess.

Mrs. Weisner. Yes, that is absolutely true, and just to follow up on that, I will say Thad is 9 years old, and he has had one surgery in his life. He had an aductive release, which means his legs are very tight, they are pulling in, and he was in danger of dislocating

his hips.

When I first started talking to doctors about the possibility of surgery for Thad, he was 3 years old, and I was told that there was a possibility that he could need surgery every 2 years. With the aggressive therapy that he has had and the consultation by the specialist where he has his hips checked periodically to make sure that they are staying seated in the right place, we have been able to limit him in 9 years to one surgery, which was also very successful because we knew just when to do it, and we did it before his condition was too far advanced and we could not go back and get the hip back in.

The boy, Alex, whom I spoke of is 10 or 11, and I am not sure how many surgeries he has had altogether, but the surgery he did have came after his dislocation because he was not followed by a specialist. He had to have a medical plate put in place. The surgery was not successful in terms of allowing him to sit up, and he had to go in for a second surgery later to get the metal plate removed. So we are already on two surgeries that really could have been one,

and probably many more additional surgeries for this boy.

So it is absolutely preventive, and we have to look—and I wish the Congressional Budget Office could take a look at how much are we going to save by not putting kids in institutions, not giving them additional surgeries. Senator HARKIN. Obviously, the problem is we budget every year, right, so you do not see those savings in that 1 year. But again,

we have to answer that.

Finally, you are such a classic case again of where the involvement of parents as sort of the "case manager" for the child, so to speak, has been so important. And again, we are going to have to have some way of ensuring that in this health care reform, parents are full participants in the case management of their children with disabilities. Providers may come and go. You may have one provider today and a different one tomorrow. Specialists come and go, but the family endures. And it is so important for the parents to be able to play that integral role. I know you have, both you and your husband, in all of Thaddeus 199 years, and will continue to do so.

This is again a good case in point where we must ensure that families and parents are involved as case managers in any health

care reform bill that we have.

So again, I thank you very much for your example and thank you

very much for your testimony and being here today.

Thaddeus, thank you for coming back. Come on up to my office again sometime, any time.

Mrs. WEISNER. Thank you for having us.

The CHAIRMAN. Thank you very much, Senator Harkin.

Mrs. Beckett, we will be glad to hear from you.

Mrs. Beckett. Senator, thank you. Senator Kennedy, Senator Harkin and members of the committee, thank you for allowing me the opportunity to come and represent and address children and family issues in health reform.

I am Julie Beckett, and my daughter Katie was the first child allowed to come home from the hospital on Medicaid without Mark's and my income being counted against her for eligibility.

Since 1981, I have been answering parents' questions and educating them on how to access health services for their children. I have heard every story imaginable as I have travelled to almost

every State in this Union.

I am currently a co-director for Family Voices, and I am joined today by Nora Wells from the Federation for Children with Special Needs in Boston, who was instrumental in helping to develop the CommonHealth program in Massachusetts, and Polly Yurango, who is another parent and co-director from New Mexico.

Family Voices has been working since January of 1993 to represent families in the health reform debate by providing them the opportunity to be involved in the grassroots level, where real

changes play out.

My perspective as Katie's mom, as a national resources on health care for families for 12 years, and now as a national coordinator for Family Voices, gives a unique perspective and a certain responsibility.

All of us would agree that children are different from adults and that children are, first and foremost, children, but that the health and the health care needs of youngsters with chronic illness and disabilities are unique.

We believe that families are fundamental to the health and strength of our society. We also know that children live in families and receive their health care coverage through their parents' benefit package. And the integrity of that fundamental composition

must be maintained.

Now let me share with you some of the knowledge I have gained over the last 12 years. First, I recognize that families of children with special health care needs have developed a special expertise as they maneuver through a convoluted public and private health care delivery and payment system with multiple levels of bureaucracy. They do this while attempting to provide a normal home life. They make tough choices daily, often unable to take a job promotion or move away from their State or community, because of the health services they will lose for their child, or they have been fired simply because their child requires too many medical services.

They are discriminated against because of an accident or illness, or their child's diagnosis based on pre-existing condition, and they are oftentimes required to pay exorbitant fees, deductibles, and

high out-of-pocket costs.

I have learned that in the public sector, eligibility criteria for State or Federal assistance programs deny access to the working poor or middle-class families, often sending them into massive debt and providing a disincentive to work and pay their own bills. Those families who do qualify face a lack of providers who will accept Government assistance clients.

And finally, coming from Iowa, I know that rural families face unique challenges, discovering a lack of providers with very little access to specialists, and they also incur many medical expenses, travel expenses, days lost from work and overnight accommoda-

tions simply to get access to those kinds of specialists.

Health care costs are climbing three times as fast as inflation despite a moderation in 1993. Health insurers continue to eliminate coverage of care for those most in need, and providers continue to cost shift.

Yet we hear that there is no national health care crisis. Tell that to Mike Fields from Montana, who has to give up his Forest Service job simply to qualify for Medicaid to cover some of his son's medical expenses—this after he has already cashed in his life insurance policy and used \$125,000 in savings so he can pay for his son Justin's uncovered medical expenses after 23 separate operations. Mike hates not working because, as he says, he has always earned his keep. He has a degree in biology, but he cannot get health insurance to cover his son, so he remains on Medicaid.

Or tell Dawn Wardyga from Rhode Island, whose family and 1,000 other U.S. Postal employees were dropped from coverage without warning when the HMO withdrew from the Federal Employee Benefits Program. Later, they were told it was because of her son Jason's medical bills, which forced the HMO to disband

and then reorganize, leaving them without coverage.

Or tell the Arizona couple whose child has complex neurological problems that there is no crisis, when both of them lost their jobs within 6 months of their child's diagnosis. Mom was told her termination was because of high medical claims, and the dad was laid off from his Fortune 500 company where he had worked for 14 years, after a new brain lesion was identified in his child.

Or tell the mom in North Carolina, with four kids with special health needs, only one of whom they can get qualified for Medicaid, that there is no crisis. She cannot get a physician qualified to treat her eligible son because of the Medicaid managed care program she is under.

Or what about explaining to Karen Arbetter from Lexington, MA, whose two sons are dying and cannot get the services required, or even access to what they had at one time under their insurance plan because of the change to an HMO managed care system that

there is no crisis.

Even eligibility for Medicaid waivers in her State limits access

to service based on technology alone.

Denying hospice services to a family in such crisis should be unforgivable. Even in Katie's case, Government bureaucracy had not kept up with medical technological advances, so she was forced to live in a hospital ICU when she could have received the same services for one-sixth of that cost at home. But no one would support

that alternative without bankrupting her family first.

We still live under those same restrictions and compromises from these same Government rules, fearing that someone will take away our home care option. Katie has again become eligible for insurance. I am not a single parent, and the only way she is eligible is because I continue to work at the University of Iowa. I have accepted temporary jobs at the health center, the law school, with various granting programs, taking very little financial incentive, simply to have health care access for Katie, because I know full well that at any moment I could lose my job, and Katie and I would once again be relying on Medicaid. That is not the way I was raised.

In 3 years, when Katie becomes 18, our lives will change again. I want an assurance that Katie can get adequate and affordable health care coverage to meet her health care needs, without discrimination or intimidation. I want the health security that the President promises. But unfortunately, some of those assurances

are not forthcoming.

Katie has saved the Federal portion of Medicaid over \$350,000 each year she has been home. Ladies and gentlemen, that is 12 years. If we as families and policymakers can make the kind of health care services available for children like Katie, who need them at home and in their communities, we can help those children with special health care needs become active, participating, taxpaying adults. That is the way Katie wants it to be, because that is the way I am raising her.

We need swift and sweeping health care reform, and we need it today—we needed it yesterday. Over the last year, Family Voices

has articulated several important points.

The first is that all families including those of us who have kids with chronic health conditions and disabilities must have access to health care. And that means universal coverage.

Second, a basic benefit package that is written for a healthy population does not include the range of services that many of our chil-

dren need in order to stay at home and out of hospitals.

Third, while the number of children with special health care needs is relatively small, the cost of caring for them can escalate if they are denied the services that are preventive in nature. If they do not get what they need, these handicapping conditions will

develop, and they will need much more expensive care.

Fourth, not only are the health care needs of our children frequently complex, but working our way through the health care maze is a very complicated and stressful process. The need for coordinating care is critical. Care coordination makes it possible for families to receive basic health services plus the specialty services our children need efficiently.

How can this be done? Well, many children currently access what they call individualized case management programs through health insurance. Most major insurers have such case management programs that provide a more flexible benefit package based on need and delivered through extracontractual agreements. Those services assure access and reimburse providers for special home and community-based services, respite care, many other services, by work-

ing closely with families.

Insurance companies have learned that individuals with special health care needs, where supported in their homes and communities through this process, improve at a faster rate and at a significant reduction in cost to their insurance plans. These case management programs, however, must have pediatric experience. If they build on the expertise, the special strengths of families, in managing the care for the child at home, they become very, very successful.

Ladies and gentlemen, Katie is under one such program in Iowa. I helped develop that program in 1985 with Blue Cross/Blue Shield of Iowa simply because they knew that Katie and I wanted to be able to help all children in our State have access to specialty care. That program has saved a significant amount of money, and we know that. Why aren't the CBO people looking into those kinds of

programs?

In summation, Family Voices supports universal coverage with no pre-existing condition clauses and a flexible, comprehensive benefit package with adequate standards for providing quality care to all children, including those with special health care needs. If necessary, we will support a supplemental package that protects the most vulnerable of these children. Quality assurance and cost-effectiveness are a major part of any plan that must be provided. Fami-

lies are tired of bearing the brunt of this cost.

Currently, the coinsurance payments under long-term care are very significant, and people have to understand that families who already have children with special health care needs pay more and more out-of-pocket costs than most people even realize. They cannot afford to continue to pay that kind of cost. Families of children with special health care needs have in many instances created their own health care systems; they have monitored their own health care costs, and they have assured quality care for their children. We believe that health care reform can learn by their example. All Americans are suffering by bearing the cost of the jerry-built health care system we currently have, and we need to fix it.

The time is now for our children and their families. We need health care reform. If I sound a little tired today, and Katie seems a little yawny—unusual for her at this time of the day—Katie and I were at National Medical Center last night at midnight because

at 9:30, Katie's gastrostomy tube, which had been totally inactive for 8 years, decided that it would swell. We had no idea what was going on. I did not try to find somebody in the city of Washington, DC. I called my pediatrician at home.

He answered the phone, gave me the best kind of medical advice he could, and after describing the things I was seeing, he said,

"Julie, I think you need to have medical care."

I called everybody in town I could think of, including Dr. Koopunfortunately, he was out of town. But I did finally track down someone who knew somebody at Children's Medical Center. So we went out there at 11:15, and it was amazing once I got to the right person. But it is getting to that person when you enter an emergency room. Knowing I can do that is one thing. I also know that the 50 poor people who were sitting in that medical emergency room, who did not have a medical card and probably did not have an insurance card, would sit there for hours and hours on end.

They took one look at Katie, were concerned, but felt that she could go home. They told me what to do, knowing I would take full

advantage of what it was they were giving me.

I turned to leave, and the nurse said to me, "You cannot go yet.
You are not registered." So I went in and registered Katie and was told, "You have to take this back to Treatment Room 8." So I took it back in. Another nurse took my paperwork, and I said, "I have already been seen. Can I go now?" And she said, "Oh, no. You have not been seen by us." And I said, "Yes, I have been seen by you.

It is okay."

The doctor said, "Oh, no. You have not been seen by me." Another additional cost was about to be put on a medical bill. And I "This child requires ventilatory support starting at 9:30 at night. She is already 3 hours delayed. If you delay it any longer, I cannot tell you what might happen, and you will be in a lot more serious trouble than we are in right now. It is best to get me in a cab and back to her ventilator." So of course, that is what they did.

But in fact, I can do that for myself because I have learned how to do it. What about all those other families to whom we are now saying, "You go out and guard your own medical care," without educating them as to how to do it, without providing them the access tools? If we do not have those care coordination programs, it will not happen.

Thank you.

[The prepared statement of Mrs. Beckett may be found in the appendix.

The CHAIRMAN. CBO does not deal with those issues, either.

Mrs. BECKETT. No kidding.

The CHAIRMAN. Those are the real issues, not to mention quality issues when dealing with the things at home. We will be debating for hours the issues of the health alliances with various diagrams and other things. But this panel is telling us what really is like, and we are grateful to you.

Ms. Sulfaro, we thank you again for coming. I suppose you are wondering, "Can't those Members of Congress just read what I said in Boston and have it incorporated here?" But I will say that it is one of the most heart-rending stories, and I wanted to have the members hear it here first-hand. We thank you very much for your willingness to share it with us.

Ms. SULFARO. I am glad to be here.

Senator Kennedy and members of the committee, my name is Sandra Sulfaro, and I am here today to testify before you on behalf of the millions of Americans with chronic medical conditions.

I want to advocate for the implementation of affordable health care coverage available to all Americans, and unrelated to employment status and location. These are all important features of the

President's Health Security Act.

I am very familiar with medical illness and problems of affordable medical care. When I was much younger, probably 5 years old, my sister died of dermatomyositis, a rare form of muscular dystrophy, at the age of 28. In those days, the 1950's to the 1970's, prednisone in 1954 was the new miracle drug available to treat her illness. The cost of the medication was \$50 per week, but my father only earned \$35 a week. My sister was denied her medication at one time due to unpaid medical bills. My father was desperate, because being off this medication was life-threatening to my sister. He contacted a representative, and I do not know if you know, Senator Kennedy, that it was your father who intervened to make sure my sister received her medication.

Not every family can rely on that type of intervention. Despite his help, my parents eventually lost their home because of all the medical bills, and we were rendered homeless for many, many

months.

I have another sister who has been diagnosed with multiple sclerosis and is currently not working and receiving SSI. Her experience and the death of my sister have given me the strength and determination to be here today. I want to do anything I can to make sure this does not happen to another family.

In the 1970's, my family was bankrupt and left homeless because of my sister's health care expenses. Now my worst nightmare is coming true. My family could be put in that same situation of be-

coming bankrupt because of my medical expenses.

I am a 45-year-old registered nurse with chronic progressive multiple sclerosis. Multiple sclerosis affects about 250,000 to 350,000 Americans. It randomly attacks my central nervous system, wearing away the control I have over my own body. Different people have symptoms that may range from numbness and paralysis to blindness. Most people are diagnosed between the ages of 20 and 40, but the unpredictable physical and emotional effects can occur for the rest of my life.

I am active with the Massachusetts MS Society which is dedicated to advancing the treatment and lives of those affected by the disease. There are about 6,000 persons in Massachusetts diagnosed

with MS.

Although I noticed symptoms as long ago as 1969, my illness was not diagnosed until 1987. I was living a relatively normal life, going to college, raising three children, and working as a nurse, but I was experiencing an increasing number of symptoms. Today, I need to use my cane for assistance and a wheelchair for any long distances at all; I usually wear leg braces as well.

I cannot stand for an extended length of time.

Three weeks ago, I was admitted to the hospital because of difficulty swallowing. At the same time, an experimental medication, betaseron, was started. The medication might slow down the progression of my disease. To date, there is no known cure for multiple sclerosis.

The cost to my family of the medication alone is \$1,000 per month, totalling \$12,000 a year. Over the past 10 years, my MS has become a very demanding disease. It is now a daily challenge

to myself, my husband, and my children.

I am married to a wonderful, hardworking owner-operator of a truck. Because of his self-employed American work ethic, he would like to continue in his field of work. Truck drivers have a limited income because of the seasonal nature of their work. My husband is paying 50 cents per gallon right now for Federal and State taxes on diesel fuel for every gallon he uses; this amounts to a cost of \$500 to \$600 per month. His operating rate of billing has not increased since 1988.

Health insurance for the self-employed is very expensive. At this point in time, I am able to carry HMO health insurance by working a minimum of 24 hours per week. Once I can no longer work, my family will have to purchase a private health insurance plan. This will cost from \$7,000 to \$8,000 a year, which will be a challenge

for us to afford.

Even if we could afford an insurance policy for the family, I would not be eligible for private insurance because of my pre-existing condition. I will have to pay my own health premium for the fist 18 months under COBRA until Medicare becomes available. Even then, Medicare only covers part of the cost of the services, and there is no drug coverage. My family will end up in a financial crisis, with a total of about \$20,000 plus per year just for medical expenses, until it becomes inevitable that I apply for public assistance and public health insurance; or making difficult trade-offs for food and keeping a roof over our head.

It is pure and simple. I am a working middle-class American citizen in fear of not being able to afford health care. I am a mirror image of thousands of hardworking Americans who feel obligated to pay and are in fear of losing their valuable assets. I could be deprived of the American dream of owning my own house and putting food on the table. I have already experienced that nightmare as a

child.

Many people choose to go without health insurance in fear of losing their homes and their livelihood. I currently work at Marlboro Hospital in Massachusetts. While working as a triage nurse in the emergency room, I encounter many situations of people who lack adequate health insurance. Many of them have no insurance at all.

Let me tell you about one of my patients. She is a woman working hard to raise her children on her own. Her husband is a 45-year-old disabled veteran with Parkinson's disease and is institutionalized. She brings her 14 and 8-year-old daughters into the emergency room for an ankle injury and an upper respiratory infection. She also told me that she has systemic lupus, but that she stopped taking her medication 3 months ago because she just could not afford it. Her health insurance coverage includes an initial \$1,000 deductible per person per family. Therefore she has to meet

the \$3,000 before her insurance even kicks in, and she has no drug benefit. Without taking the prescribed medication, she will surely increase the chance of an exacerbation of her disease. With the father also hospitalized, who will take care of the children? This family has an inadequate health insurance plan, but they cannot seek the medical services that they need.

I have worked as a nurse for over 25 years, and today it is very common for me to see people who cannot afford proper care. In my opinion, my colleagues burn out because of the sadness we feel over

the decline in service and humanity.

I know from my own experience that we can work really hard and still not be able to earn enough money to make ends meet. We can develop life-threatening illnesses and not be able to earn a livelihood. Fear becomes a daily reality because we are no longer secure that our future will hold opportunities for us and our children.

Please give us back some hope. Pass the necessary legislation that will ensure affordable, comprehensive medical coverage for all Americans regardless of our current medical or economic situation.

Thank you.

The CHAIRMAN. Thank you very much, all of you, for your testi-

mony.

We always hear as a result of these types of hearings, "Well, you just went out and found two or three or four people who have fallen through the cracks in the health care system." How many times have we heard that in the past 27 years? What we are hearing today are the real family situations that exist across this country. This is what is real and this is what is happening to our fellow citizens. Each day we fail to take action is an indication of the neglect of our society in being a humane nation. A nation that I believe all of us want it to be.

I appreciate very much all of your testimony. We have a final panel which we want to try to hear from, but I want you to know how grateful we are to all of you. We are going to keep your recommendations and suggestions in mind. We will work closely with you as we begin to fashion the legislation, and marking it up in the

next few weeks.

As the President, the First Lady and others have indicated, we are going to get this job done. When we do, you will have played an extremely important role in addressing these needs. You ought to know that and understand it, because it is very, very true.

Senator Harkin?

Senator HARKIN. Thank you very much, Mr. Chairman. I will just echo the sentiments you have just expressed, and thank you for being here, Julie and Katie. And Katie, you were smart. You came this time, but you did not come a couple of weeks ago, right? It is a little better weather this time.

Ms. Beckett. A lot better.

Senator Harkin. I'm sorry you got ill last night, and I am sorry you had to go through that process. We have heard from everybody else, but we have not heard from you, Katie. Are there any thoughts that you would like to express? Tell us about your future plans. What year are you in school, now?

Ms. Beckett. I am a sophomore.

Senator HARKIN. A sophomore. What is ahead?

Ms. Beckett. I am thinking about being a writer, and I really do not want to have to give up that dream because of my health insurance and because of my problems. It is not fair.

Senator HARKIN. Knowing you are facing the age of 18, you

mean.

Ms. Beckett. Yes, yes.

Senator HARKIN. So that—well, I just thought about this, Katie—so that in fact, what you want to do and what your future plans involve to a great degree hinge upon health care options that you have; right?

Ms. Beckett. Yes.

Senator Harkin. You have just given me something else to think about. So not only is it, in terms of universal coverage and health care, necessary to improve the quality of people's lives in terms of their health alone, but also the other things in their lives—what they are going to do, how they are going to work, what careers they are going to pursue.

Ms. Beckett. Yes.

Senator HARKIN. I am glad you brought that out. It is not just health, but it is a lot of other things, too, down the road.

How are you doing in school—OK? Ms. Beckett. Yes, I am doing fine.

Senator HARKIN. Good for you. I like that self-assurance. That is confidence, I will tell you.

Mrs. BECKETT. We could get a couple grades up, I think. [Laugh-

ter.]

Senator HARKIN. Spoken like a true parent. I just went through that with my kids.

Mrs. BECKETT. She is missing school today, so maybe I should

not say that.

Senator HARKIN. You know, Mark Twain once said: "I never let school interfere with my education." So it is a good education being here.

Mrs. BECKETT. Yes, I figure she is getting a pretty good education today. One of the things that I think is of concern for Katie and for myself is that we have always done what was best for her to give her as normal a life as possible—and I mean a normal life. She is a regular teenager. The first thing, we got in the hotel room yesterday, "Mom, my Walkman is out of batteries." You know, if they do not have the headphones on, you are not communicating with them anyway.

But the thing is that what I want to be able to give her is that same kind of future she has had for her past, which is the ability to get the health care services she needs, at an appropriate cost, from people who know how to take care of her, not just anybody.

My greatest fear last night was having someone play with Katie's medical care. I did not want just anybody looking at this kid and saying, "Oh, look at all the scars this child has." Thanks. I do not want to go into it all the time, and she does not deserve that. She is 15 years old, and she can speak for herself.

Senator HARKIN. Yes. I just want to say, Julie, that I have here a copy of the Iowa Blue/Cross Blue Shield individual case management that you mentioned that you worked so hard on, and again,

my compliments for getting this done.

Mr. Chairman, this is really a great thing that we have in the State of Iowa that Julie and others have worked so hard to get, and I would hope that whatever plan we put through here would incorporate the same kind of individual case management—the family support, the home health. One thing that we have not mentioned this morning that has come up in the past and will come up again is respite care, respite support for families. That is going to be very important, but again, getting the parents involved in that individual case management. So I hope that this is the kind of thing that we can replicate in whatever health care plan we come up with.

So again my compliments to you, Julie, on all that you have done nationwide in focusing attention on this and on getting the families involved. I appreciate it very much. And Katie, thank you for being

here. Get those grades up. Study hard.

Mrs. BECKETT. They are not low.

Senator HARKIN. I know, but every parent says you can get them

up. I know how that goes.

And we will get that health care thing taken care of well before you are 18, okay? Do not worry about that.

Ms. Beckett. Good. I will remember that.

Senator HARKIN. Senator Kennedy said you can count on him; we will get it done. [Laughter.]

The CHAIRMAN. We will, we will.

Senator HARKIN. Thank you all very much.

The CHAIRMAN. And we want to thank you, Mr. Johnson, very much as well for your testimony. We are grateful for your comments.

Our colleague Senator Simon wanted to express his regrets to the Weisners from Illinois. He heard them in Illinois at a previous hearing, and he is necessarily absent today, over at the Budget Committee at a meeting on the balanced budget amendment.

We want to thank all of you very, very much for being here.

We are pleased to have with us some of the leading experts on disability policy on our third panel. Each has contributed significantly to advancing the understanding of health care reform as it

impacts individuals and families with disabilities.

We will hear from Gina McDonald, chairperson of the health reform committee of the National Council on Independent Living. Ms. McDonald has been a tireless advocate of assuring personal assistance services to people with disabilities and is currently executive director of the Kansas Association of Centers for Independent Living in Topeka.

We will also hear from Linda Long, who is a co-chair of the Massachusetts Ad Hoc Committee on Health Care Reform and Disability. Ms. Long is a lawyer with the Disability Law Center in Boston and has worked for several years securing the necessary medical services for low-income persons with disabilities. She has been a real hero for thousands of the disabled in Massachusetts, and we are very, very glad to have her here.

Finally, we will hear from Janet O'Keeffe, who is co-chair of the Consortium for Citizens with Disabilities Task Force on Health. The Consortium is the largest coalition of national organizations concerned with Federal policy affecting citizens with disabilities and their families, with over 100 organizations represented. Dr.

O'Keeffe is also Assistant Director of Public Policy at the American

Psychological Association.

We are glad that all of you could be here. We have had a good morning so far, and you are really the clean-up batters. We know that not only from your own testimony which you put forward, but also from all of our opportunities to work with you. All of us on this committee value your guidance and assistance and advice on these matters. You are really incredible spokespersons for what is happening to people with disabilities, and we value very highly your comments.

If we could, I would like to start with Linda Long. We are glad

to hear from you. It is nice to have you here again.

STATEMENTS OF LINDA M. LONG, CO-CHAIR, MASSACHUSETTS AD HOC COMMITTEE ON HEALTH CARE REFORM AND DISABILITY, BOSTON, MA; GINA McDONALD, CHAIRPERSON, HEALTH REFORM COMMITTEE, NATIONAL COUNCIL ON INDEPENDENT LIVING, TOPEKA, KS; AND JANET O'KEEFFE, CO-CHAIR, HEALTH TASK FORCE, CONSORTIUM FOR CITIZENS WITH DISABILITIES, WASHINGTON, DC

Ms. Long. Thank you, Senator, and thank you to all the mem-

bers of the committee who came today.

My name is Linda Long, and I am here today to speak on behalf of the Ad Hoc Committee on Health Care Reform and Disability, which is a group of people with and without disabilities working to ensure a universal right to health care which is meaningful for all people, including people with disabilities.

I am here today to share our perspective on health care reform, and as you noted, I am also an attorney with the Disability Law Center in Boston, MA, where I represent mostly low-income people

with disabilities, particularly developmental disabilities.

One thing I would like to note, and I think it is a very important point, is that laws such as P.L. 94-142, Section 504, and the ADA have all made a dramatic difference in the lives of people with disabilities. I know that I have seen tremendous strides toward inclusion and integration during the course of my lifetime. I know I would not be sitting here if it were not for those things.

I would like to take this opportunity to thank you, the co-chairs and the members of this committee, for your efforts in this regard and to applaud the President and Hillary Rodham Clinton for their efforts to remove one of the last remaining barriers to full integration and productivity for all Americans by establishing a universal

right to health care.

As people with disabilities have left the confines of homes and institutions over the last several years, modern technology has worked to replace the functions which our bodies will not perform and make it possible to participate in our fast-moving world. One man whom I know who has a severe speech impediment uses an augmentative communication device called a "Touch-Talker" to replace his voice. Through the use of this device, he is able to communicate well enough to live on his own and attend college. Last year, he was voted president of his student council. All of this was accomplished without the need for intrusive surgery.

When viewed from the perspective of facilitating function, which is really the bottom line for most people with disabilities, there is no difference between a Touch-Talker and a wheelchair; they simply replace different body functions. It is very important to include coverage for these services of all kinds, all kinds of assistive technology, in health care reform.

Just as it is arbitrary to distinguish between a Touch-Talker and a wheelchair, it can be equally arbitrary to cover acute services and not long-term care services. One major step forward and a fundamental reason for support of the Clinton proposal among people with disabilities is the inclusion of home and community-based services for severely disabled individuals in the health care reform

package.

Across the country, many people with disabilities still languish in hospitals and nursing homes because they cannot get personal assistance services at home. One of our own ad hoc committee members, Charlie Carr, spent 7 years in Middlesex County Hospital in Massachusetts because that was the only place where he could get someone to help him get out of bed in the morning. It was only personal assistance services in the community that enabled him to get out of the hospital and live in the community, where he is now the director of an independent living center.

The inclusion of such services as an integral part of our national health care reform is one of our highest priorities. One concern that we have is that there seems to be little recognition in the health care debate that all health care is long-term care. Elderly people and people with disabilities are not the only ones who need long-term care. We all have to take some responsibility for our own

health and work on it to maintain it on a daily basis.

What we seek is health care which is truly universal and which provides us with the means necessary to take responsibility for our

own health and well-being on a daily basis.

To ensure that our health care system is truly universal, we must preserve certain aspects of the Medicaid program as a wraparound for low-income people. We would like to see this wraparound coverage offered both to people who receive cash assistance and those who do not. Otherwise, one of the greatest injustices of our current system will be perpetuated. People who have worked all of their lives still will not have access to essential health care. I would just like to note that I speak to those folks rather frequently, and I am always telling them, "Yes, I know. It is not fair you do not have coverage, but it is perfectly legal." I would hate to see that still be the case after health care reform is enacted.

We would like also to emphasize the importance of access to preventive services, defined broadly, defined inclusively. In this health care debate, "prevention" is usually defined to include only those services which prevent otherwise able-bodied people from becoming ill or disabled. There is very little discussion about what constitutes preventive care for people with disabilities. People with disabilities are often at risk, as you heard before from others, of serious complications or of secondary disabilities, without services such as outpatient rehabilitation. I can point to my own experience to illustrate this point.

About 1 year ago, at the age of 30, I began to experience intense pain in my hip and lower back. I felt as if I was about to snap in half at the waste. I, like many other folks with disabilities, have worked very hard to achieve my current level of functioning. To make it possible for me to live an independent and productive life, I had ten operations and countless hours of physical therapy as a child, and full braces. Without interventions such as physical therapy and the little AFO that I am wearing right now, I would have been at serious risk of damage to the bones and nerves in my spinal column—I checked on this with my doctor before I came here and told you this, so I want you to know that it is for real. I could have lost a great deal of what I had worked so hard to attain and been forced to live with chronic pain for the rest of my life.

When one has learned to live with a certain level of disability, it is very hard to lose ground, no matter what the starting point. And it means no less to me to lose my current abilities than it

would be for a person without a disability.

We feel strongly that language regarding rehabilitation therapies must explicitly include maintenance of function. These are preven-

tive services for people with disabilities.

Also included under preventive services for people with disabilities are outpatient mental health services. These services are essential to maintain people in the community and prevent costly inpatient hospitalization. Language regarding these services should recognize their cost-effectiveness and their prophylactic capabilities. And the copayment should not be so burdensome as to become a barrier to obtaining care.

Speaking of barriers, we believe that a truly universal health plan must offer the same services to everyone, regardless of how they acquired their disability or the timing of its onset. And it is very encouraging to hear Judy Feder say that she is willing to work with your staffs to ensure that people with congenital conditions will be covered under the various sections of the health care

reform.

A failure to provide these services to people with congenital disabilities, particularly children, only serves to create the risk of greater health care costs in the future and a tremendous loss of human potential and productivity. And it also flies in the face of years of public policy regarding people with disabilities and our families.

Historically, managed care programs have screened out people with disabilities, sometimes with congenital conditions and chronic illnesses, and have relied upon incentives which discourage access to specialty care. For these reasons, they contain inherent risks for

some people with disabilities.

In Massachusetts, the Medicaid program recently instituted a mandatory managed care program for Medicaid recipients, including people with disabilities. The jury is still out on how we are ac-

tually going to fare.

Managed care has in some instances encouraged continuity of care and more intelligent use of health care resources. However, it has also disrupted longstanding relationships with physicians for arbitrary reasons, such as geography. There have also been problems in the enrollment process, much of which has taken place

through the mail. Many people, particularly those with cognitive limitations, have had difficulty in sorting through the voluminous—and I do mean voluminous—materials sent to them to figure out what to do, how to find a personal care clinician, thus making

it very difficult for them to make informed choices.

It will take time for managed care systems to learn how to accommodate the needs of people with disabilities. Managed care will have to become more flexible and individualized, something which I think may work to everyone's benefit. For example, these systems will have to become flexible enough to accommodate the need of a person with a developmental disability for more time with her treating physician, because she will have a harder time understanding how to follow up on treatment, and it will take more time for the physician to explain to her what to do.

Even so, some people may never get their needs properly met in such settings. For this reason, it is essential to provide an afford-

able point-of-service or fee-for-service option.

A good example of an affordable program which provides a low-cost but flexible benefits package is a Massachusetts program called the CommonHealth program, which I believe Julie Beckett mentioned earlier. This program allows people to buy into a comprehensive benefits package which includes long-term care, rehabilitation services, and other critical services for people with disabilities. Recipients pay a premium set on a sliding fee scale. This coverage can act as their primary insurance coverage or as a wraparound. Many people have told me over and over again what an important difference CommonHealth has made in their lives. I have never—not once—heard anyone complain about the premiums. In fact, I would have to say that people are proud to pay for it.

Programs such as this can serve as models for a national comprehensive benefits package that includes long-term care, preventive therapies for people with disabilities, and others, thereby

meeting the needs of all people.

These are just a few of the many, many issues which we need to address to make health care a truly universal right. I would be more than happy, as would many others here from Massachusetts and around the country, to provide you with further information.

Thank you for the opportunity to come and speak with you today.

It is a real privilege.

[The prepared statement of Ms. Long may be found in the appen-

dix.]

The CHAIRMAN. Thank you very much for your comments and also for all of your help on this issue. We want to give you the assurance—and I know I speak for Senator Harkin and other members—that as we move on through this process in the next few weeks, we will actually be marking up and giving life to these words. And we understand that words in this business are key—they are key in any business—but as we were delayed in our civil rights bill because of the difference between "significant" and "manifest," I found it difficult to understand the significance, but how they had been interpreted in courts and lower courts and circuit courts had important implications in terms of protecting different rights of individuals as they applied in terms of discrimina-

tion on the basis of race. So these words are enormously important because they have been interpreted, and many of them are tied in with courts, law, decisions that have been made, and also by tradition and how they have been interpreted to give the assurance of service.

So we want to give you the assurance that this is a continuing process. Your testimony today is enormously important, as I know you have been working with Senator Harkin and other members of this committee over a long period of time. And we want you to know it is important not just today, but as we continue the process of marking this up, to get your continued advice, and we want to give you the assurance on that.

Ms. LONG. Thank you.

The CHAIRMAN. We will now hear from Gina McDonald. Ms. McDonald. Thank you, Mr. Chairman, Senator Harkin.

My name is Gina McDonald. I am executive director of the Kansas Association of Centers for Independent Living in Topeka, KS. Today I am representing the National Council on Independent Living, or NCIL, as the chairperson of the health reform committee.

I also experience a disability. When I was 10 years old, I sus-

tained a head injury, and as a result, I have a hearing loss.

NCIL, or the National Council on Independent Living, is a grassroots national organization run by and for people with different types of disabilities. In 10 short years, NCIL has established itself as the national voice on the independent living movement, rep-

resenting centers for independent living.

Centers for independent living are community-based, cross-disability, not-for-profit corporations which are governed by people with disabilities. Centers provide services to people with disabilities, including individual and systems advocacy, information and referral, independent living skills training, and peer counseling. There are more than 300 consumer-run organizations in the United States today.

As the previous panel clearly stated, there is indeed a health care crisis in this country. According to the United States Census Bureau, there are 49 million Americans with disabilities. Of those, 34 percent are not covered by private health insurance. Of people who experience significant disabilities, 43 percent have no private insurance. That is far above the 25 percent of all Americans who

are not covered.

Clearly, the need for health reform in the health care system is most evident and most painfully obvious to people with disabilities and to their families and friends. The National Disability Rights Agenda has been built over the years through Section 504 of the Rehab Act, the Americans with Disabilities Act, and the Individuals with Disabilities Education Act. The key to the success of that agenda is national health reform, which includes universal coverage that is affordable, accessible and comprehensive.

Many people with disabilities and their families cannot fully enjoy the promises of ADA, IDEA or 504 without a major change in access to the health care system in this country. NCIL believes that health care, including access to long-term care, is a fundamental right of all Americans, just as ADA, IDEA, and 504 have as-

sured civil rights.

There is indeed a health care crisis when people who cannot afford enormous premiums go without health care until their situation escalates to require costly emergency room care. There is indeed a crisis when people with disabilities are promised equal rights to employment, but are afraid to accept a job because they will lose their Medicaid benefits and know that they will not be covered by their company's plan, if there is one.

A man I know was recently offered a job in Washington. It was a big promotion in status and salary from his job in Illinois. When he got to Washington, no health care plan would cover his pre-existing conditions. He could not use his COBRA benefits because the HMO in Illinois does not transfer to Washington. The ADA assured him his right to be considered for employment based on his skills. However, the lack of health care coverage substantially diminishes

his quality of life and therefore his ability to succeed.

Let me share another story with you. I know a farmer in Lincoln, KS who has three children, one of whom has a disability. He cannot get health insurance for his family because of his disabled child. Even when he tried to get coverage for the rest of the family and not include his child with the disability, he was turned down. He attempted to get Medicaid benefits for his child but was turned down because he owns land and therefore has too many assets. His options are to lie to the insurance company and not reveal that he has a child with a disability, which he refuses to do; he can get a divorce and take custody of all his land and his two nondisabled children, and give his wife custody of their disabled child, who would then be eligible for Medicaid; or he can put his child in an institution where she will get health care, at a cost to the State and the Federal Government of about \$100,000 per year. The cost to the child with the disability would be her future.

None of these options are acceptable, and none of these options are consistent with the promises of equal rights and inclusion that have been made to people with disabilities by both the Democrat

and Republican administrations.

There is indeed a health care crisis when we can claim we have the best health care in the world, but not all of our citizens can

afford to have access to it.

The National Council on Independent Living is advocating for a plan that will provide coverage to all Americans with no pre-existing condition exclusions; a plan that will provide universal coverage must be one in which all benefits are equal and available to

all, regardless of income or employment status.

Universal coverage means long-term care that includes personal assistance services. It means a comprehensive durable medical equipment package including assistive technology, which is health care. And it must have strong language that ensures non-discrimination against minorities, including people with disabilities.

People with disabilities and their families represent a minority that continues to grow every day as society ages and technology improves. One in six Americans will have a disability at some point in their lives. If you design a package to meet the needs of people with disabilities, you will meet the needs of all Americans, at all stages of their lives.

Thank you for the opportunity to speak to you today. Senator HARKIN [presiding]. Thank you very much, Gina, for your testimony, and again, my compliments to NCIL, a very good organization.

[The prepared statement of Ms. McDonald may be found in the

Senator HARKIN. Next we will hear from Janet O'Keeffe, co-chair of the health task force of the Consortium for Citizens with Disabilities.

Ms. O'KEEFFE. Good morning, Senator Harkin.

The CCD Health Task Force is a coalition of over 65 national consumer advocacy professional and provider organizations that are working to enact comprehensive health reform that will meet the needs of person with disabilities and chronic illnesses. We greatly appreciate this opportunity to present our views on this crucial issue.

Our written testimony includes detailed comments on the Health Security Act, with specific recommendations for refinements in legislative language, and we would like to submit the entire testimony

for the record.

Senator HARKIN. Without objection.

Ms. O'KEEFFE. As you have heard from many of the previous panelists, lack of adequate health care coverage is a critical issue for many persons with disabilities and chronic illnesses who have experienced first-hand the myriad problems with our current system. For many persons with disabilities, lack of access to comprehensive health care undermines the promise of the Americans for inclusion, independence. Disabilities Act empowerment. While many Americans with disabilities and chronic illnesses are locked into jobs because they are afraid of losing their employer-provided health insurance, as Ms. McDonald noted, many others are locked out of jobs because they are afraid of losing their Government-provided health benefits.

There are numerous problems with our current system which were detailed previously, and I just want to highlight a couple of them, the ones we are most concerned about. Obviously, pre-existing condition exclusions is a major issue; the whole notion that people can be defined as "medically uninsurable"; ever-increasing unaffordability, which is compounded by the practice of experience ratings; inadequate benefits, particularly long-term care and support services and personal assistance; and the practices in managed care plans that were earlier discussed that create financial incen-

tives to deny necessary care.

All of these problems constitute a real crisis in our health care

system which must be addressed by any legislation.

The previous panelists have mentioned many of the reforms that are needed to assure comprehensive health care, and many of these features may be viewed as abstract technical details of varying importance. But it is very important to remember that they have very real consequences, and each and every one of them is needed if we are to have meaningful reform. I would like to briefly go through a couple of them.

First of all, the elimination of pre-existing condition exclusions will mean an end to job lock and an end to the fear of losing insurance, of losing one's life savings, of having absolutely no economic security only because you were unlucky enough to develop a chron-

ic illness or a disability.

Guaranteed, specified, comprehensive benefits means that a person with diabetes whose leg is amputated will get the prosthesis and therapy he needs to go back to work. It means that children like Thaddeus Weisner and others with cerebral palsy will get the therapies and the equipment they need to go to school. And it means that persons like Harry Johnson and others with AIDS will get the medicines that they need to live.

Home and community-based long-term care and personal assistance will mean that a young man with a spinal cord injury can go to school and get a job, instead of lying in bed, developing bedsores, which will require costly treatment in the hospital. It means that parents will not have to institutionalize their children with mental retardation in order to get necessary services. And it means that a working woman will not have to give up her job and her own eco-

nomic security to care for a mother with Alzheimer's disease.

Community rating, which is often under attack by some members of the insurance community, means that when you get sick or when you retire at half your previous salary, your insurance premium will not increase from \$300 a month to \$600 a month. Risk adjustment and reinsurance, also essential for health care reform, mean that efficient health plans with good outcomes will not go out of business because they attract a disproportionate share of high-cost persons. I think, as Ms. Beckett said earlier, the need to go to those centers of excellence, to go to the providers who have specialty services, once a provider or a hospital gets a reputation for providing really good services, people with disabilities, people with chronic illnesses are going to flock to those centers, and as a result, the premiums may go up because more people who are high utilizers are going there. It is very necessary for centers, for those health plans that attract this large number of persons with disabilities or high users that they get a risk adjustment, and that the insurance plans that get a lower number of persons with high cost then similarly get a lower premium. It is really essential that that risk adjustment take place, because otherwise these very good plans could wind up being penalized and eventually become unaffordable for people.

Effective cost containment. We cannot stress strongly enough the importance of this because without effective cost containment, insurance simply will not remain affordable. It is already a problem for many people in the country, but if we continue at the double-digit rates we are going, it is not going to stay that way. And unfortunately what always happens is that the increased costs are shifted to consumers in the form of higher premiums, higher deductibles, higher copayments, higher taxes for the Government programs and the subsidies, and eventually, reduced benefits. So effective cost containment is crucial and must be included in any

bill.

Eliminating incentives to underserve will mean that people will actually receive the benefits that are in the guaranteed benefits package. Again, many of the speakers here talked about the hassle factor they have to go through to get services from a gatekeeper

who does not understand the specialized health care needs of certain children with disabilities. It will also mean that managed care plans will not be allowed to reduce a physician's salary because he or she made more than their specified number of referrals to specialists. I do not know if you are aware of this, but some health plans will negotiate a salary with a physician and will withhold from 15 to 20 percent of that salary. And they tell him, "If you stay within our limit of a certain number of specialist referrals, and you stay within our limit of hospitalizations, then you will get that 15 to 20 percent of your salary at the end of the year; but if you exceed that, you do not get it." So clearly, physicians are going to think twice before they make a referral. And particularly, let us say they have gotten through half the year and they think, "I am getting to the top," then for the last part of the year, they are going to be very reluctant to send persons for referral because it is going to mean a cut in their income. We think these types of financial practices should be totally outlawed.

I understand there is currently legislation to make kickbacks—in other words, when a physician makes a referral to a lab or a center, that they should not get a kickback for doing that, and similarly, they should not be denied their salary for making that referral. And it is really essential that we have protections around

this particular issue in managed care plans.

Reducing financial barriers to service means that a teenager with severe epilepsy since childhood will not reach his lifetime maximum limit at the age of 17 and then be faced with absolutely no insurance thereafter. It means that a family whose child has leukemia will not be bankrupted by onerous cost-sharing year after year. Many of the out-of-pocket limits assume that people will not have catastrophic expenses on a yearly basis, so a \$2,500 or \$3,000 cap on out-of-pocket expenses is reasonable if that is all you incur once every 10 years; but if a family incurs that kind of out-of-pocket expense year after year after year, we really need to look at additional protections for those families.

Finally, universal coverage is the foundation for all of these re-

forms.

Health care reform is not just another difficult and complex legislative issue, although I am sure you understand the complexity of it, but it is important to understand that it is literally a matter of life and death. I think many of the witnesses here have made that point very eloquently. When you are working on this legislation, it would be very helpful to imagine the devastation that comes when you hear that your child or your spouse or you yourself have developed a chronic illness that is terminal or disabling; and then imagine getting that same piece of information when you do not have insurance or when you are afraid you will lose your insurance because you are not going to be able to work.

It is really essential that the health care security that every

Member of Congress has be given to every American.

In closing, I would like to say that President Clinton has demonstrated tremendous leadership by sending his Health Security Act to the Congress, and now, obviously, the Congress must assume the leadership role. As you said earlier, both Democrats and Republicans in Congress and the White House worked together to

enact the Americans with Disabilities Act, and just as the ADA was a bipartisan achievement, so must health care reform be a bi-

partisan achievement.

Illness or disability will ultimately affect every person regardless of their political persuasion, so it is time to put aside partisan differences and recognize that a Nation's health care system has a single purpose, and that is to meet the needs of all of its citizens. To the extent that reform meets the needs of persons with disabilities and chronic illnesses, it will meet the needs of all Americans.

Thank you very much for this opportunity.

[The prepared statement of Ms. O'Keeffe may be found in the ap-

pendix.]

Senator HARKIN. Thank you very much, Dr. O'Keeffe. You have submitted a whole package of recommendations here, which are very good. I think I am familiar with most of them by now.

Ms. O'KEEFFE. There are a lot of them, and more coming, too. Senator HARKIN. We will receive them gratefully, I can assure

you.

One of the suggestions—and I read the testimony last week, so I knew this was coming, and I mentioned it earlier to Ms. Feder—was a recommendation that an advisory committee, under the auspices of the national health board, should be established to address the needs of persons with disabilities and chronic illnesses, and that a formal process for incorporation of consumer input in the development of the report cards—remember I talked about what if it gets an "A" for people without disabilities, but for people with disabilities, it gets an "F," and what do you do about that? And I have been a strong supporter, obviously, of consumer involvement, the kind of work that Julie Beckett is involved in with Family Voices, getting parents and families involved in this, and consumer input.

So this strikes me as something that is not there right now, but we really ought to look at it in terms of having some kind of an

advisory committee set up on these national boards.

I just wonder if any of you have thought about that, or would you be supportive of that, and how might that work; do you have any

thoughts on that at all?

Ms. McDonald. Yes, Senator. In fact, in the written testimony that NCIL provided, we also advocated for consumer involvement at every level, not just looking at advisory committees. But as we have heard, parents and people with disabilities really are sophisticated in terms of knowledge of what their disabilities are about, and if we can get input, and if we can create a system that is going to work for them and that they understand, I think it is the same as any other thing that we create—if we can get input from the people who are going to have to live that system, then we are going to be a lot better served. The idea of consumer control and looking outside as opposed to always looking at a medical model and the least expensive way, as Dr. O'Keeffe explained, of providing services, to really look at something that is going to provide the best services for people. And in the long run, it will be less expensive.

Senator HARKIN. Linda, anything else?

Ms. Long. All I can add to that is that in addition to being able to offer very pragmatic advice as to how a health care system will

work on a daily basis, I think that having consumer involvement

helps to keep everybody honest.

Senator HARKIN. That is true. Again, I do not know what is going to happen with the alliances. I see that one of my colleagues on the House side, Congressman Starke, has said something about the alliances being gone, that they could not find any support for them. Well, that has not been my experience. Those of us who have supported the President's program, even though I may have some problems with his program in some areas, I do not have any problems in terms of having an alliance set up. The State legislatures would set them up. They would determine the boundaries; it would be sort of a State option. And the alliances would be consumerdriven.

And the boards of these would be consumers and not providers. So it would seem to me that this is the most effective way of having the consumer input plus keeping cost controls on from the consumer standpoint and making sure we have quality of health care. So if you do not have the alliances, I do not know what you

have.

It seems to me also that with the alliances, as we develop the legislation and assuming that we provide that we will have the alliances—and maybe we will do it on this side; I do not know what the House side is going to do—that we have some provisions in there that indicate to the States that we expect that a portion of the board that makes up the alliances would have to be representatives of the disability community. I do not know whether we mandate that; I do not know, because they will vary from State to State. But there ought to be a clear indication that we expect that to happen and that there should be people representing the disability community.

I do not know if you have looked at that. Now, that is a step down, I understand, from the national board, but it seems to me

you want that involvement right at that alliance level also.

Ms. O'KEEFFE. Yes, and I am very glad you brought up the alliance issue, because we are hearing the same thing from the House side, and it is a great concern. We strongly support the alliance

structure for a very simple reason: It spreads risk.

The major problem in our current health insurance market is the segmented market whereby insurers can try to skim off the best groups, the lowest risks. Even though pre-existing condition exclusions and other egregious medical underwriting practices will be prohibited under health care reform, there are still very many subtle ways that insurers can market their plans and to discourage the enrollment of persons with high costs. So the alliances are the way to eliminate a lot of that.

Also, contrary to what people are hearing on television in the "Harry" and "Louise" ads, I would like to say very strongly that the alliances will assure consumer choice. As Gina has pointed out, the man who came here to get a job, his HMO did not operate here. If you go to a health alliance, and you pick out the plan you want, then you can change jobs, you can become unemployed, and you still keep that same insurance plan. And if we do not have health alliances, people would still be locked into the particular insurance plan that their particular employer gets at a given point.

So we strongly support the alliances both for their impact on assuring a greater choice of health plans for consumers but also, most

importantly, because they spread risk.

And with regard to the advisory board, yes-I do not remember exactly the number of persons on the advisory board. I do not think it is a large number. And given the range of conditions and disabilities, the fact that there might be children's groups who want a children's advisory panel or other groups concerned about under-service in other areas, certainly, at the very least I think an advisory board is the way to go, and clearly to have persons with disabilities and to have the kinds of specialists that Ms. Beckett said were so essential to assuring the type of care that she needed. If we just look at the practice of medicine today and the number of subspecialties, it is really an impossibility to try to be an expert in every single area, so it is essential that we have a range of experts as well as consumers to give input to the board in terms of their decisionmaking.

Senator HARKIN. Well, I like the suggestion, and I think as we develop this legislation in this committee, we are going to look at

the possibility of setting up that kind of an advisory board.

The counsel to the Subcommittee on Disability Policy, Andy Imparato, tells me that the national health board is only seven people; you are right.

Ms. O'KEEFFE. Yes, it is small. It is hard to represent everybody. Senator HARKIN. That is a lot to put on seven people. So I think the advisory board would be something that we should not only consider, but perhaps adopt, as we go through the process here of marking it up.

I am curious about the CommonHealth program in Massachusetts. Now, your former coworker here, Andy Imparato-who, by

the way, speaks very highly of you-

Ms. LONG. Thank you.

Senator HARKIN [continuing]. Says that it is quite a good system, and State-funded. I am going to find out more about it and how it operates. Evidently, people buy into it-right?

Ms. Long. That is correct. Actually, I have with me a fact sheet that you might find helpful that I can leave with you.

Senator HARKIN. OK. Why don't you leave it here, then, if you do not need it right now? I would like to take a look at it. Andy Imparato said he is going to make a memo for me, so that might suffice for the memo, right?

Ms. Long. Yes. It explains it pretty well.

Senator HARKIN. I would like to take a look at it. There might be something there that we might want to look at, too, on a national level.

I think the points have been well-made by all of you as we are ending the hearing today, on universality of coverage, making the pool large, no pre-existing conditions, making sure that we provide for consumer input. And again underlying everything that you have said here is the idea that in terms of cost savings and cost-effectiveness, we have just got to look beyond the near horizon. We have got to look beyond that near horizon and understand that in terms of lifetime costs and what we are saving up front, it is a problem with the Congressional Budget Office, obviously; they have a short horizon. And we have to get over that in this health care reform bill.

You have stated it very eloquently here—and making families participants; making sure that we have extracontractual services available; and ensuring that if we have managed care systems that the provider act as the coordinator and facilitator, not a "gate-keeper." I never did like that "gatekeeper" concept. Too often, gates get closed on people who need it the most. So some kind of a coordinator and facilitator, but letting that individual again have specialized services beyond what the primary care person may recommend or envision.

So these are all very important topics and something that means

a lot to us here.

If there is nothing else, I am going to adjourn the hearing. Is there anyone who wants to make a last parting shot across the bow

as we move ahead here?

Ms. O'KEEFFE. Senator Kennedy said earlier that so often people say we dragged a few people out who are falling between the cracks, and I think it is essential to note that the 37 million who are uninsured at any given time, the 65-plus million who are uninsured over periods of time, the many more who are underinsured, which is just as much of a problem—what good is insurance if you get to the hospital and it says we will pay for part of it, but not for the other part. You are still left with unaffordable bills.

We have a real crisis, and we feel we just cannot wait any longer, that we really have to have health care reform this Congress. And we know that you will work for this. And just to reiterate, we are looking forward to President Clinton signing this into

law before the end of the year.

Senator HARKIN. I appreciate that. I hope so, too.

I will close on this note. I was out over the break period and heard a lot of comments about the fact that the Business Roundtable had not supported the President's health reform package. I noted with interest that the Washington Post in reporting on this had said that the members of the Business Roundtable were meeting in a hotel, one of the nicer hotels in Washington, the night before, and they had counted 20 limousines lined up outside, waiting on the people in the hotel who were in the meeting.

So I was asked about the Business Roundtable not supporting the President's health care reform package, and I said it seemed to me that we ought not to base whether health care reform is good or bad or needed or not on what people who ride around in limousines have to say about it. I daresay they have got their Cadillac

coverage.

Ms. O'KEEFFE. Absolutely.

Senator HARKIN. And I think what we have to do is to decide whether it is good or bad, or whether we need it or not, based upon average Americans out there, people that you represent—not the people who are riding around in limousines and meeting in the fanciest hotels in Washington, DC.

If we keep that in mind and keep that our focus, we will get that

health care reform bill passed this year.

Thank you very much. Ms. LONG. Thank you.

Ms. McDonald. Thank, you. [The Appendix follows.]

### APPENDIX

#### PREPARED STATEMENT OF JUDITH FEDER

Mr. Chairman and Members of the Committee:

Thank you very much for this opportunity to share with you what the President's plan will do to help people with disabilities. Their special circumstances amplify their needs and illustrate poignantly the failures of the current health care system to provide the security of coverage when help is needed the most—the President's plan provides universal health care coverage for every American, regardless of their needs or risks.

Congress—particularly Members of this Committee—has demonstrated special concern about the ability of people of all ages with chronic disabilities to obtain access to health and long term services. The President recognizes, as you do, that a Health Security Card alone cannot guarantee that all Americans will receive necessary health coverage. To achieve this goal, the Health Security Act includes additional measure that will provide special protections and secure access and quality for people with disabilities. Let me share them with you.

#### SECURITY OF COMPREHENSIVE HEALTH CARE COVERAGE

All Americans will have the security of comprehensive health coverage—with no exceptions. People with disabilities or chronic illnesses will no longer be subject to the precipitous loss of coverage they face today. No one can lose their coverage. Under the Health Security Act, hospital services are covered; doctor visits are covered; prescription drugs are covered. In addition, certain extended care, hospice services, and outpatient rehabilitation services are covered. These services and others offered under the benefit package become a crucial link for the very survival of people with certain disabilities or illnesses.

#### CONTINUITY OF CARE

The Health Security Act assures that all Americans will have a choice in selecting their providers and health plans. Each individual will be able to enroll in a traditional fee-for-service plan, join a network of doctors and hospitals, or join an HMO. In addition, all health plans must offer a point-of-service option—individuals will

not be restricted to the plan providers.

To further guarantee continuity of care, all individuals will have access to medical specialists for unique services they need. All health plans must make sufficient arrangements with providers to assure the provision of all items and services covered by the comprehensive benefit package. In addition, plans must contract with academic health centers for services that are rare and performed in enough frequency at these sites to ensure quality. Further, states may require plans to contract with centers of excellence they identify to further guarantee appropriate access to care.

The essential community provider requirements guarantee access to services of federally-funded clinics and other providers delivering care in difficult-to-serve areas. Qualifying providers, e.g. those being funded by Ryan White, Community and Migrant Health Centers, programs for the homeless, family planning, and maternal and child health, are guaranteed payments for covered services from all health plans. This program assures that vulnerable populations have continued access to practitioners with experience in meeting their needs, regardless of the health plan in which they choose to enroll.

#### PROTECTIONS AGAINST DISCRIMINATION

The Health Security Act assures that no individual is discriminated against in obtaining comprehensive coverage. Health plans will no longer have lifetime limits on coverage. Health plans will offer an open enrollment, accepting everyone applying for coverage at that time without charging a higher premium to those with a pre-existing condition. States and alliances further assure that no one faces barriers to care based on disability, race, ethnicity, age or gender.

To protect health plans that attract disproportionate numbers of vulnerable individuals, the Health Security Act assures proper payment through alliance-based

risk-adjustment and reinsurance systems.

To ensure the confidentiality of patients, national privacy protection standards are established. These standards limit the uses of individual-specific information, in the new data system, to those necessary for the delivery of health care services. Privacy protection as applied to health care information will be a continuing focus of the National Health Board.

#### SPECIAL SERVICES

The Health Security Act leaves in place certain programs to address additional

needs of those with disabilities or chronic illnesses.

Safety net providers: Current safety-net programs will continue to receive funding for services beyond the guaranteed package. Transportation, outreach, case management, translation, and personal support services remain critical for vulnerable popu-

lations and will be sustained under the Health Security Act.

Medicaid: All Medicaid eligible children will be eligible for a new federal program of wrap-around services that supplements the comprehensive benefits package. States will continue to receive matching payments for wrap-around services for adults who receive SSI or AFDC benefits and for dual eligibles. Long term care Medicaid services (e.g., nursing home, ICF/MR, home health, personal care, etc.) continue to be available as under current law. In addition, all states will be required to take medical expenditures into account in determining financial eligibility for Medicaid coverage of nursing home care. Also, Medicaid patients in institutions will be able to keep \$50 per month for their personal needs, up from a minimum of \$30 per month.

Medicare: Medicare remains essentially unchanged, except for the addition of a new prescription drug benefit. As you know, Mr. Chairman, Medicare's coverage for people with disabilities who are under age 65 requires a two-year waiting period. That will not change. However, under the President's plan this population would be assured of coverage for health care services during the two-year waiting period.

Long Term Services: By assuring access to health coverage for all Americans, the Health Security Act responds to one of the gravest concerns of people with disabilities. But access to health care coverage alone will not provide the long-term supports that people with disabilities and their families need to live in their own homes and to lead productive and satisfying lives in their communities.

The President's plan offers real hope and tangible long term support to children with disabilities, their families, and to working age adults in the form of a major expansion in community-based long term services. This new program will provide significantly increased Federal funding to help states offer a wide array of personal

assistance and related supports to people with severe disabilities.

Eligibility for this new program is based on functional and cognitive impairment rather than age, type of disability, or income. Eligible persons will have the opportunity to receive a wide array of long term supports including attendant services, assistive devices, home modifications, and home maker services, in addition to vouchers and direct cash payments. States must permit participants who are able to manage their own services to do so—including hring, training, and firing their own providers. Consumers and their representatives will be required to be involved in all aspects of the design, implementation and oversight of the new Home and Community Service program to assure that it is responsive to the wide array of needs of people with disabilities.

When the program is fully phased in, approximately \$38.3 billion new Federal dol-

lars will be available annually to provide service to over 3 million persons.

#### TAX CREDIT

The Presidents long term care plan will also provide tax relief to people with disabilities who want to work but cannot afford the high out of pocket costs of personal assistance services. The Health Security Act includes a 50% tax credit for persons with disabilities for out of pocket expenditures on personal assistance and related services, up to a maximum of \$15,000 per year (or earned income, if less)—for a maximum credit of \$7,500. This tax credit phases out for persons with incomes between \$50,000 and \$70,000.

#### TRANSITIONAL INSURANCE REFORM

As you know, comprehensive reform will take a few years to fully implement. During the interim it is critical that we protect existing insurance coverage for employers and families. We must assure that insurers do not drop the most vulnerable in anticipation of a system in which they are forced to compete based on price and quality, rather than their ability to attract the healthy and avoid the sick.

The Health Security Act, therefore, includes a series of transitional insurance reforms that guard against the most egregious abuses by health insurers prior to the

creation of a fully reformed market and the formation of health alliances.

These reforms include:

Health insurers are prohibited from terminating or failing to renew coverage for a group or individual, except in cases of non-payment of premiums, fraud, or misrepresentation in an application for coverage or claim for benefits.

Insurers are required to provide coverage for new employees of an employer

that purchases insurance, regardless of health status.

Premium increases cannot be varied according to the health status of the

group or individual.

Exclusions for pre-existing conditions are limited, and individuals who are continuously insured are not required to meet a new waiting period for preexisting conditions when switching coverage.

Self-insured health plans may not arbitrarily reduce benefits for high cost ill-

nesses.

The National Transitional Health Insurance Risk Pool is established to provide coverage to individuals who are unable to obtain private coverage because of their health status.

And, insurers will be required to obtain prior approval for premium increases

higher than the threshold percentage set by the Secretary.

These transitional insurance reform by no means represent comprehensive reform, as ultimately envisioned by the Health Security Act. They will, however, protect against the most extreme abuses we see in the insurance market today, and they will ensure an orderly transition to a system that guarantees health security for all Americans and effective control of health costs.

#### CONCLUSION

Mr. Chairman, approximately 39 million Americans, including many people who have special needs, go without health coverage. Far too many people most in need of services, are uninsured or lose their insurance just when they need it most. We can either address the problem head on—organize health care delivery and financing, so that system works for all Americans—or deny the problem and let the system grow more and more unfair, expensive, and out of control. We must join forces and solve this problem. We must work together to create a rational system where those who need health care and long term services the most have security of care.

# PREPARED STATEMENT OF MARILYN HOGAN WEISNER

Good morning, Senators. My name is Marilyn Hogan Weisner.

I would like to introduce my husband, Tom and my son, Thaddeus. I would also like to thank you sincerely for allowing me to speak at this hearing today and participate in the health care debate. Thaddeus, who is the one who prompts me to be here today, is nine years old and has cerebral palsy. He has spasticity, rigidity and quadriplegia, which means that his muscles are extremely tight and difficult to

move and that all four of his extremities are involved in his disability.

If you could spend a few minutes with Thaddeus you would see that, despite the tremendous difficulties he has had his entire life, he is a pleasant, happy boy. And if you could spend a little more time, you would also discover a distinct personality and an active intelligence beneath his apparent disability. You would discover the same thing about thousands of other special needs children across this country. We often use the term "birth defect" to describe the medical condition of these children. But these are not defective children, these are beautiful examples of the human spirit.

I would like tell you a little about Thaddeus's history, because his case illustrates some of the successes of the present health care system and the problems that this

national health care proposal may present for special needs children.

Thaddeus was born in the Solomon Islands while his father and I were in the Peace Corps. He had a difficult birth, did not breath quickly enough and suffered damage to his brain. He immediately had problems which have taken him years to overcome. He couldn't nurse or suck on a bottle. His nervous system was so traumatized that he couldn't relax enough to get to sleep. When he did finally fall asleep he could not sleep for more than a couple of hours at a time, and often would be up the entire night and day. He had severe and chronic colic. He suffered various repeated infections. In his first three years of life, he was never healthy for more than two weeks at a time. And finally, he had a serious delay in his motor development. He reached none of the milestones of normally developing children with the exception of one. On the day he turned eight weeks, he woke up with a smile, achieving that milestone just in time. I think that on that day, his dad and I were able to smile for the first time in eight weeks, too.

The three doctors available to us when Thaddeus was born were general pediatricians from Britain and Canada with no special training related to children's disabilities. My repeated questions about what was wrong with my son and what we could do to help him were met with the repeated answer that there was nothing we could do for him. In fact, they suggested we stop trying so hard to do something and just accept things the way they were.

I took Thaddeus back to the States when he was nine months old. The first doctor I saw spent a total of five minutes with Thad before deciding that he had no intel-

ligence.

He said that Thaddeus would probably have a lot of respiratory infections, such as pneumonia, and implied that if I wasn't very vigilant I could be rid of him sooner. I was dismayed after this visit and sought the opinion of another specialist who correctly diagnosed Thad with cerebral palsy and referred us for the proper treatment. ment. Thad began receiving physical and occupational therapy to relax his tight muscles and help him learn proper patterns of movement, and speech therapy to teach him how to eat and help him find a way to communicate. He was referred to an orthopedic surgeon to ensure he did not develop contractures, or severe shortening of his muscles, and dislocations.

Seven years later, Thaddeus took his first steps. Last November, with the help of his higher heads a welked down the sigle as ring beaver at my sister's wedding.

of his big brother, he walked down the aisle as ring bearer at my sister's wedding. That was a fat of immense proportions for him. And he loved being able to do it. He is beginning to grasp an object with his hands, giving him the potential to feed himself and locomote himself around with an electric wheelchair one day. He is using his eyes to communicate by looking at a word or an object to indicate the answer to a question or a choice he would like to make. He is currently enrolled in a regular first grade classroom where he is learning reading and math. He is beginning to work on a computer that he an operate by just looking at the choices presented on the screen. In short, he has the potential to become a functioning, productive adult who can contribute to his own support.

Thad's progress has not been as dramatic or seemingly as "miraculous" as that of Christy Brown whose life was portrayed in My Left Foot. In fact, his success is not a miracle at all. It has taken years of work, regular visits to specialists, weeks of therapy, and hundreds of minute victories to bring Thad to the threshold of communication, mobility and function. Perhaps Thad's life or those of other disabled children would not make a good movie. But, just like Christy Brown, Thad and these other children are becoming much more than limp figures confined to the cor-

ner of the family room floor.

Had we not brought our son home to seek the opinion of specialists who were more knowledgeable about my sons symptoms than the general pediatricians, our son would not be where he is today. Had we been under a national HMO with rules anything like the those of the largest HMO in our area, where we would not have been allowed to reject the assessment of the first doctor we saw in the States and look for a doctor with a better understanding of his disability, our son would not have made the progress he has to date. And had our insurance company refused to cover physical, occupational and speech therapy, our son would simply be an intelligent and feeling person trapped forever in a body that doesn't work, with no way to make use of the abilities that he does have.

Our son was diagnosed and began treatment at nine months of age. And though, when you consider how much a child learns in the first year of life, nine months is a lot of time to lose, we are thankful that his diagnosis didn't come any later. It is because of this early intervention that our son has made so much progress.

But early intervention is as much prevention as it is treatment. Besides promoting development and the attainment of functional skills in our son, early diagnosis and treatment have prevented further medical complications which later would re-

quire expensive medical procedures to correct.

Without an early diagnosis, without the consultation of the specialists who understand his disability, and without adequate and consistent physical, occupational and speech therapy that he has over the past eight years, Thad's body would be respeech therapy that he has over the past eight years, Thad's body would be restricted by contractures of his muscles; he would suffer hip dislocations. He would require repeated painful surgeries to overcome, but never fully correct, these prob-lems. He would have progressing scoliosis which would eventually impinge on his internal organs causing damage to these organs. He would never have learned to suckle, and, later, to chew and swallow solids. More than likely he would have had a tube surgically implanted in his stomach where we could pour in tasteless nutrients in order to sustain him.

Without these medical services, he may not even have been able to grow up at home with his family. He wouldn't share holidays with his brother and his cousins; he wouldn't go to the birthday parties of friends. He wouldn't be in his first grade classroom. He wouldn't have achieved any of the accomplishments of which I spoke earlier. He may have been in an institution, which is what happens to many children who are unable to receive appropriate medical care for their disabilities. It becomes very difficult for parents to care for disabled children when they have continued medical complications, when the gap between what they are able to do and what other children their age can do continues to widen and parents become less able to cope with the growing physical demands and the emotional stresses of caring for someone who is totally dependent for years with no hope of ever becoming inde-

Think of your own children and what a relief it was when you didn't have to change diapers anymore, when they could tell you what hurt when they were sick, when you didn't have to guess what they wanted, but they could tell you exactly

in words.

I have changed diapers for nine years. For many years longer than the normal child, I have had to use a hit or miss method to find out why Thad was sick or what he needed. In some ways, caring for Thaddeus has been like having a new baby every year for nine years. But because of the therapy and the medical services he has had, I can see progress and every year he can do more and it gets a little easier. Because of these services I can anticipate the day when he will be able to communicate effectively, operate a computer, contribute to his support, and, hopefully, never reside in an institution. Without a continuation of these services that will never happen. Without these services he will not make more progress and will

most likely regress.

It would be a great loss for our family to have to institutionalize Thad. Thad is filled with a joy of living. He has a special relationship with each member of our family. He has a sense of humor. We love him and take pride in his accomplish-

ments as any parent does any child.

Thaddeus is a living example of the need for insurance coverage for early diagnostic services, specialist consultation and physical, occupational, and speech therapy for the congenitally disabled in any health care plan which is passed by the federal government. It is of great concern to me and many, many other parents of special needs children that national health care include these services for children with congenital disorders.

It does not take any special training to see the difference between a child, like Thad, who has received appropriate services at an early age and had a continuation

of these services and the child who has not.

The sad story of another child I know with cerebral palsy illustrates this. Try to picture Alex, whose disability is similar to my son's but who did not receive needed follow-up and therapy services. His arms are contracted, his fingers are deformed, he cannot bend his hips to sit, his hips are twisted as the result of a dislocation which was corrected by surgery and a metal plate, and his head is nearly permanently thrown back. When he is able to get his head forward, he cannot stay that way for long because his skeletal structure has changed and he can no longer swallow easily with his head forward. He will undoubtedly undergo many expensive surgeries, not to improve his condition so much as to slow the effects of these contractures. He will spend weeks in hospitals at a very high cost. These deformities make this boy non-functional, in spite of the fact that he has shown the potential for communication and interaction. His mother is loving and does everything she can for him, but at some point she may find it necessary to institutionalize him.

If a national health care plan without these services had been in place tens years ago, it's quite possible that this same bleak scenario would have described Thad's

situation and that of thousands of special needs children across this nation.

We have been assured by the president that no one will lose benefits and, in fact, many will gain benefits with his health care plan.

My son receives therapy and follow-up medical services right now under the health insurance policy provided by my husband's employer. If these services are not included in the national plan, he will lose those benefits. The children whose pictures and stories I have included at the end of this testimony also receive these benefits under their parents' insurance policies, portions of which are also attached. If the final legislation passed by Congress does not include coverage for those services, these children will lose those benefits. More than 1500 children at 10 centers in my area alone, and thousands more across this country, are covered for these services by their existing insurance policies. Unless the coverage for these services are an express part of a national health care plan, these children will all lose the benefits for these services, services which are crucial to their well-being and may be their only chance for a decent life.

Mrs. Clinton declared in a recent radio interview that the president's plan will provide the same benefits that are currently available to those who have, in her words, "good" insurance policies. Parents of special need children know that these "good" insurance policies do cover therapy, do cover diagnostics for early interven-

tion and do cover specialist medical follow-up for special needs children.

If the Senate does not place these services in the guaranteed benefits package of the national health care plan, can we be assured that any insurance company will offer these services as a covered benefit? If the national health care plan only provides therapies for the restoration of lost function rather than the development and maintenance of function, special needs children will be excluded. Most congenitally disabled children are not regaining function they have lost. They are developing function for the first time. If it only provides for therapy for those suffering from illness or injury, then special needs children who have lifetime conditions rather than illnesses or injuries will be excluded. If it only provides for sixty consecutive days of therapy, then our children will never have the opportunity to develop functional skills. If it does not provide for diagnostics and specialist care, the benefits of early intervention will be eliminated.

While there is some diversity now in terms of what is provided, the health care program is going to standardized the basic package. If these kinds of services are left out, then our son and thousands of others now and in future generations are

going to be denied the right to reach their potential.

Can we afford not to provide these services to special needs children? There is a cost to denying therapy and follow-up medical services to congenitally disabled

children.

Special needs children who do not receive proper medical services are often placed in institutions when their parents can no longer care for them at home. Children who do not become functional and independent as children become dependent adults. Dependent adults also often end up in institutions. Caring for someone in an institution for a lifetime is far more expensive than providing them with therapy and follow-up services early enough to impact their development. Medical services provided for by insurance companies are paid for with private money from premiums and insurance company profits. Institutions are usually tax supported.

Educational costs increase. The less functional a child is, the more it costs to edu-

cate him or her.

And there are social costs to neglecting the medical needs of special needs children. Caring for a child who is not developing properly is stressful to a family. The divorce rate for families with special needs children testifies to this. Seventy percent of families with special needs children experience divorce. Diagnostic and therapeutic services not only provide support for the child medically, but also for the family as a whole. The knowledge that you can do something to help your child removes the feeling of hopelessness that can accompany the raising of a special needs child. The function that can be gained by the child may even gain the parents the time to maintain their relationship.

Special needs children need specialists to manage their care. It is the specialists who are trained to determine what the disorder is, who know what treatment our children need, what problems to anticipate, and what new discoveries are made that

can help our children.

Parents of special needs children recognize that the movement by insurance companies in this country, with or without reform, is toward the HMO as a preferred method of health care delivery. But we also know that HMOs have not been as effective in cutting health care costs through efficiency as they have been through cutting benefits. And the benefits they most often cut are the benefits for the very services that disabled children need most.

Many HMOs are reluctant to allow referrals to specialists; they are reluctant to approve referrals to the comprehensive diagnostic teams at the children's hospitals;

and they often refuse to approve therapy for special needs children.

The stories of several children who have coverage by an HMO illustrate how many HMOs are not responsive to the medical needs of special needs children.

Charlie was born prematurely with hypoglycemia, resulting from his mother's diabetes, at a respected children's hospital in the Chicago area. He was told by the specialists there to return to their diagnostic clinic at four months of age and every four months thereafter in order to monitor his development. Charlie's HMO primary care physician refused to make the referral to the diagnostic clinic and refused to recognize that Charlie even had any problems with his motor development. Possibly he was trying to avoid the black mark many HMOs give doctors who refer to specialists. At two years of age, Charlie still had not begun walking. By chance, at a visit for a well-child check-up, this regular physician was not there and Charlie was seen by a new associate. He immediately noticed Charlie's tight muscles and the scissoring of his legs and realized that Charlie had cerebral palsy. This doctor suggested that Charlie be seen by a pediatric neurologist immediately. With the influence of the second doctor, Charlie finally received the referral.

He was diagnosed with cerebral palsy and physical therapy was begun under a

very limited benefit. When the benefit ran out, the HMO was extremely reluctant to extend the benefit, even though the therapist had every reason to believe, that with continued treatment, Charlie would walk independently. A battle ensued between the parents and the HMO. Eventually, the benefit was extended. However, had the HMO doctor originally made the referral for Charlie to see the specialists as recommended, his cerebral palsy would have been diagnosed earlier. Had he been diagnosed and begun treatment earlier, Charlie would have begun walking earlier and needed less therapy to do so. By delaying diagnosis and therapy, the HMO caused this child to have a more serious delay and actually caused the cost of this child's treatment to increase.

Another six children, with diagnoses varying from cerebral palsy to an undetermined neurological condition, were approved for therapy and began receiving therapy through the therapist employed at the HMO clinic. When the HMO therapist quit, these children were denied continued therapy, not because they no longer needed it or because their diagnoses had changed. The HMO cut these children off from therapy because the HMO would have to pay someone other than itself to provide treatment. The determining factor for this HMO for providing services was not

whether the services were necessary or whether they were a covered benefit, but rather whether the HMO would make money by providing the service.

Numerous other children of which I know, who have coverage under a wealthy and powerful HMO in our area, have been diagnosed with a disorder, received a recommendation for treatment, and then were denied treatment because this HMO only allows very short term therapy.

While we have all heard tales of the abuses of the present system, the problem

with special needs children in terms of treatment is seldom "too much, too soon or too often". It is almost always "too little, too late". The direction and philosophy of many HMOs as it relates to special needs children appears to be "not at all".

We have come a long way in understanding child development. We know that the earlier we work with a child who is delayed in development, the better chance they

have for the maximum development of their potential.

And finally, disabled children are not a special interest group. Disability can hap-

pen to anyone at any time and is a naturally occurring fact of life.

For these reasons and all of the above reasons, any health care reform must include therapy, diagnostic and specialist services for special needs children. Otherwise we will be taking a tremendous step backward.

In conclusion, I am speaking to you for three purposes today. First, I am here to say that I believe that no congenitally disabled child should ever be denied the services he or she needs to reach his or her potential and that universal coverage for

all children is something this nation owes itself.

Secondly, I am here today to fight for Thaddeus's future and for the future of thousands of defenseless disabled children who will lose existing medical benefits for specialists and therapy unless Congress specifically includes them in final health care legislation. There is enough courage among these children and their parents to move mountains. Please do not take away their hope.

My third purpose is to make sure that there is access to specialists who understand the warning signs of the multitude of disorders which afflict children from birth. We thank God that we were able to access the specialists we needed to make the proper referrals for Thaddeus and who knew what type of treatment would best serve his needs. Without these he may well be in an institution today instead of

appearing before the United States Senate.

There will be those who argue that these benefits are not affordable, even though the medical cost of rot providing therapeutic and proper diagnostic services is more expensive in the long term. But beyond the columns and rows of financial data accumulated by anonymous number crunchers, is another ledger—a moral ledger. Can anyone in this room today look me in the eye and tell me that any health care legislation which denies benefits, indeed excludes existing benefits to disabled children, can be called reform?

I am one person speaking today, but I am speaking for thousands of parents. We are asking you to defend the future of these special needs children, whose bodies may not be whole but whose spirit and determination are incredible to behold. We are asking you to see to it that they continue to have access to the services that

are their basis for hope, at a cost that can be afforded.

It is not military or economic leadership that has made this nation great—it is our moral leadership that makes the world look up to us. As this nation moves for-

ward, once again, it its efforts to provide a decent life of health and opportunity for

all, will it remember the weakest among its citizens?

These children are your quiet constituency, Senators. Some of them cannot stand, we ask you to stand up for them. Some of them cannot grasp, we ask you to take their hands. Some of them cannot speak, we ask you to be their voice.

The Lord said, "Whatever you do for the least of these, you do for me." Matthew,

Chapter 25, Verse 40.

Thank you very much. [Additional material is retained in the files of the committee.]

### PREPARED STATEMENT OF JULIANNE BECKETT

Senator Kennedy, Senator Harkin and Members of the Senate Labor and Human Resources Committee: Thank you for the opportunity to address your committee on

the issue of health care reform for children and their families.

I am Julie Beckett. My daughter, Katie, was the first child allowed to come home from the hospital on Medicaid without Mark's or my income being counted against her for eligibility. Since 1981, I have been answering parents' questions and educating them on how to coordinate the training for health services for their children. I have heard every story imaginable, have traveled to almost every state in the union. I am currently one of the co-directors for Family Voices. Nora Wells, a parent from the Federation for Children with Special Needs in Boston, and a Family Voices co-director has joined me here today to represent thousands of our members. We each have special expertise in children and financing their health services. Senator Kennedy may already be aware that Nora was instrumental in the development of Commonhealth for the state of Massachusetts.

Family Voices has been working since January 1993 to represent families in the health care reform debate by providing them the opportunity to be involved at the grassroots level where the real changes in the health care system play themselves

out

Family Voices organized to assure that voices of children and their families were heard during state and national health care reform discussions. All of us would agree that children are different from adults and therefore their health care needs are not the same. Our experiences as families tell us that our children are first and foremost children but that the health care needs of youngsters with chronic illnesses or disabilities are unique unto themselves.

Family Voices has spent months gathering stories to educate policy makers about the intricacies of our current system-where things work and where they don't

Family Voices believes that families are fundamental to the health and strength of our society. Because children live in families they receive their health care coverage through their parents' benefit package. The integrity of that composition is

important to maintein.

We believe every child and family is unique. However, families of children with special health care needs have developed, out of necessity, a special expertise as they maneuver through a convoluted public and private health care delivery and payment system with multiple levels of bureaucracy. They do this while still focusing on everyday life and attempting to provide as normal a home as possible for their children with special health care needs. Let me give you some examples of what thousands of American families face every day!

Families have had to make tough choices. They are often unable to take a job promotion or move away from their state, or even community, because of the health

services they will lose for their child.

Many family members have been fired simply because their children require too many medical services. Their employers succumbed to the pressures of escalating

insurance premiums and let them go.

Many families have been discriminated against due to accident, illness, or their child's diagnosis. Pre-existing condition clauses that insurers renegotiate with employers (oftentimes after the fact) often eliminate families from coverage for needed services and result in high out-of-pocket expenses for them.

Eligibility criteria for state or federal assistance programs deny access to the working poor or middle class families, providing no relief and often sending them

into massive debt.

Those families who do qualify for SSI or Medicaid face lack of providers who will accept government assistance clients because of low reimbursement rates or concerns about liability issues.

Coming from Iowa, I know that rural families face unique challenges. For rural American families, the lack of providers in general severely limits access to specialty services for their children with special health care needs. The out of pocket expenses they must incur for travel, days lost at work, and overnight accommodations alone also add to the financial and emotional stresses for rural families.

Health care costs are climbing three times as fast as inflation despite a moderation in that climb in 1993. Health insurers continue to eliminate coverage of care for those most in need and providers continue to cost shift.

And yet we hear that there is no national health care crisis.

We need swift and sweeping health care reform and we need it today!

Over the last year, Family Voices has articulated several important points based on family stories.

First: All families, including those of us who have kids with chronic health conditions and disabilities must have access to health care. That means universal coverage.

Second: a basic benefit package for a healthy population will not include the range

of services that many of our children need.

Third: while the number of children with special health care needs is relatively small, the cost for caring for them can escalate if they are denied services that are preventive in nature, that can negate secondary and tertiary handicapping conditions from developing.

As you can see, not only are the health care needs of our children frequently complex, but working our way through the health care maze is very complicated. The need for coordinating care is critical for our children. Care coordination makes it possible for families to access basic health care PLUS the specialty services our chil-

dren need quickly.

Thousands of children with special health care needs currently receive services which are outside their insurance policy's basic benefit package through individualized case management programs. Most major insurers have such case management programs which provide a flexible benefit package based on need and delivered through extra contractual agreements. These case management programs assure access and reimburse providers for special home and community-based services by working closely with the family and/or the consumer. Insurance companies have seen that individuals with special health care needs who are supported in their homes and communities can be medically managed and can improve at a faster rate and at a reduced cost to their plans.

However, these individualized case management programs only work for our children if there is pediatric medical expertise and if there is a willingness to utilize

the strengths of families in these case management efforts.

Family Voices has collected hundreds of horror stories about the lack of medical knowledge regarding our children on the part of insurers, nursing agencies, and other providers hired by insurers. These particular stories raise our concerns around "managed care plans" and "gatekeeper" programs. We recognize the need for a monitoring agent to act as a case coordinator between agencies and health plans with the families as integral partners on the decision-making team.

But we know that those monitors or case managers or gatekeepers must have the

special expertise that only a well trained health professional has.

In summation, Family Voices supports:

(1) Universal coverage with no pre-existing condition clauses in order for health care reform to really provide adequate and appropriate health services for all Americans.

(2) A flexible comprehensive benefit package with adequate standards for providing quality care to all children including those with special health care

needs

(3) Quality assurance and cost effectiveness. Families of children with special health care needs have, in many instances, created their own health care system, monitored their health care costs and assured quality care for their children. We believe that health care reform can learn by their example.

We must recognize that all Americans are bearing the cost of a jerry-built health care system loaded with duplication of paperwork and administrative overhead, complicated eligibility criteria, little coordination with related programs, no guarantee of portability between states, and disincentives for families to move out of poverty, the discrimination from insurers and their lack of expertise in medically managing our children and their families adds to our expensive and unwieldy system.

The time is now-our children and their families need health care reform!!

[Additional material is retained in committee files.]

#### PREPARED STATEMENT OF GINA McDONALD

My name is Gina McDonald. I am the executive director of the Kansas Association of Centers for Independent Living in Topeka, KS. I represent the National Council on Independent Living (NCIL). I serve as the chairperson of the health reform committee. I am also here today because I have a disability. When I was 10 years old, I sustained a head injury and as a result, I have a hearing loss.

The National Council on Living is a grassroots, national organization run by and for people with a variety of disabilities. In 10 short years, NCIL has established itself as the national voice of the independent living movement, representing centers

for independent living.

Centers for independent living are community based, cross disability, consumer controlled, nonresidential, nonprofit corporations which are governed by people with different types of disabilities. Centers provide services including individual and systems advocacy, information and referral, independent living skills training and peer counselling. There are more than 300 consumer-controlled centers in the United

States today.

The need for personal assistance services is as old as disability and aging. The proactive attempts to ensure availability of PAS so that people with disabilities can participate in society, employment and independent living began with the independent living movement. The I.L. movement and its centers changed the premise of rehabilitation from one of "fixing the individual" to a belief that we need to "fix" society so that people with disabilities can equally participate. There was a shift from professionals knowing what is best. That is known as consumer control. You will be hearing a great deal about consumer control in this testimony.

The need for reform in the health care system is most evident and obvious to People who experience disabilities, and to their families and friends. Section 504 of the Rehabilitation Act, the Americans with Disabilities Act (ADA) and the Individuals with Disabilities Education Act (IDEA) were the beginning of a national disability rights agenda. The key to the success of that agenda is national health reform. Many people with disabilities cannot fully enjoy the promises of ADA, and IDEA without a major change to the access to health benefits in this country. Like the ADA, NCIL believes health care, including access to long term care, including PAS,

is a fundamental right for all Americans.

A man named Ed was recently offered a job in Washington. It was an advancement from his job in Illinois. When he got to Washington, because he has a disability, he cannot get on a plan. lie cannot use his COBRA benefits because the HMO in Illinois does not transfer to Washington. ADA ensured that he had access to employment, but without health reform, he cannot "afford" an advancement.

NCIL has begun and will continue to collect stories of the day to day indignities and health risks people with disabilities and their families experience. NCIL will be sending them to you to counter the false arguments that deny the health care

crisis in this country.

There is indeed a health care crisis when people who cannot afford enormous premiums go without health care until their situation escalates to require costly emergency care. There is indeed a health care crisis when people with disabilities are afraid to become employed because they will lose their medicaid benefits and know

that those services will not be replaced by a health plan, if there is one.

My friend Joe had a heart condition and was a single leg amputee. lie was brilliant when it came to computers, and he volunteered time at my organization to help me get payroll on line. When I offered him a permanent position, because of his skills and because I knew his family could use the money, he refused. He had medicaid benefits that he was afraid to lose. The insurance plan our company had would not cover his pre existing conditions. Even though the pay was good, it didn't match what he got in benefits.

There is a crisis when we can claim so eloquently that the United States has the best health care in the world, but not all of our citizens can afford to access it.

I know a farmer from Lincoln, Kansas who has three children, one of whom has severe disabilities. He cannot get health insurance through a company for his family because of his disabled child. Even when he tried to get coverage for the rest of his family, and not his disabled child, he was turned down. He attempted to get medicaid for his child, but because he owns so much land they do not meet the income eligibility requirements. His options are to lie and say he doesn't have a disabled child, and he may be able to get coverage, but he refuses to do that. His only other option is for he and his wife to get a divorce, and he take all the land and gives the mother sole custody of the disabled child. Then the child would be eligible for medicaid benefits. How can we pretend there is no health care crisis?

We must see a change in the system. People with disabilities and their families represent a minority that continues to grow daily as society ages and technology increases.. One in six Americans will become disabled at some point in their lives. In order to assure adequate health care that will meet the needs of all Americans at all stages of their lives, NCIL want to share the following findings.

NCIL applauds the Clinton administration for its efforts to develop a health reform package that assures universal coverage with no pre existing conditions that

includes long term care services.

Any health care plan that is developed needs to include at least the following:

### Universality

Real health security means comprehensive benefits that can never be taken away. All Americans deserve equal health care, without regard to employment status. No pre-existing condition exclusions, waiting periods or underwriting of high risks

in the acute care benefit.

Guaranteed community rating requiring insurers charge the same communityrated premium to every individual within a regional alliance regardless of health

Comprehensive basic benefit package with no lifetime limits. Ensure consumer CHOICE throughout regional alliance menu of plans.

Regional alliances controlled by employers and consumers and not insurers or pro-Mandatory participation, if there is to be universal coverage. Without universal

coverage, we will continue to see health care costs skyrocketing.

The provision of quality services as they are needed, will reduce the cost both in terms of cost effectiveness and inhuman suffering, if they are delivered when need-

The plan must include provisions for long term services. Home and community based services (HCBS), will allow individuals with disabilities to live in the community. These services are health care, and must be included in a plan, if people with

disabilities are to have equal access.

We now have the most expensive system in the world. Small businesses and all of us are paying for an expensive system now through taxes and hidden costs. Let's create an equitable affordable system. The Administration's plan to use community ratings is certainly a step in this direction.

Available options for low-income families providing discounts at the public ex-

pense.

### Accessibility

Recognizes the validity and importance of compliance with the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act of 1973.

Simplicity in standardized forms.

There should be no pre existing condition exclusion allowed for any reason.

The plans cannot set caps or limits that would tend to discriminate against people with disabilities.

Plans must have flexibility that allow for the primary caregiver, or the "gate keeper" to be a specialist, or in some cases a team of specialists, if that is the need of the person with a disability. Many people with disabilities have had bad experiences with "gate keepers". Due to disincentives of the plans to provide "unneeded" services, the gate keeper tends to minimize needs.

Incentives for providers under managed care to serve a certain number of clients per month must not interfere with the rights of people to have adequate time with

a provider to meet the needs of people with cognitive and other disabilities.

I have the story of a man who, after an accident became spinal chord injured. He received excellent rehabilitation services, and eventually moved-into his own apartment, and, after services through vocational rehabilitation, he became employed.

A year later, he noticed a small skin breakdown on his back. He went to his primary care physician, a general practitioner, who was the gatekeeper to specialist care, and also the person designated to keep costs down for the health care plan. The G.P. treated this young man with some medication and covered the breakdown with a dressing. However, the dressing was the wrong type, which caused further breakdown and infection set in.

Three days later, this young man had a massive infection, and had to be rushed to the emergency room. That one small problem was now an infection and breakdown to the bone, which required acute care and a long period of bed rest. In some cases, plastic reconstructive surgery, or some type of skin transplant may have also been necessary. He was out of work, or on short term disability and away from his job for a number of months. Even after months of treatment and recovery, he had

trouble with this area.

So the moral of this story is, if this young man had been referred to a specialist in the treatment of spinal cord injury, or had a gatekeeper with this knowledge, in most cases, the skin breakdown would have been treated appropriately and would not cost our health care system thousands of dollars. In the long run, with the intent of saving money, and no preventive care, our health care system allowed this example to occur. Clearly, with the provision of adequate treatment with the proper specialist care, individuals with disabilities can receive comprehensive health care at an affordable cost.

## Choice of providers

This is critical for people with disabilities because of their unique health care needs. We must have a plan that adequately provides for personal assistance services (PAS) and a basic benefits package that is truly universal, in that it does not omit services that people with disabilities need to function and maintain health.

There need to be assurances that health plans will have information about the level of physical accessibility of the offices of the providers. What percentage of the providers can be located in inaccessible offices, if we say that people with disabilities have equal choice?

Specific guidelines about availability of sign language interpreters for office visits as well as in acute care settings need to be established. Methods of assuring that the providers have information about their responsibilities for access and interpreters and other auxiliary aides need to be established.

### Quality assurance and accountability

The accountability features included with regard to the governing boards of the regional health alliances and the report cards by consumers of the services are supported by NCIL. However, there needs to be a further breakdown in the report card system to determine the level of satisfaction by people with disabilities. An alliance may get an "A" on their report card for provision of services to the general population, but get an "F" with regard to services for people with disabilities. There must be quality assurance for provision of services to people with disabilities. If quality assurance is determined by the alliance, there is little incentive for ensuring quality to a population that may have, or is perceived to have more costly needs for specialty services.

NCIL believes that without strong regulations from the National Board, there will be no incentives to assure quality services, and the same issues will arise again as we see today, that is that health care services are only really available for the non-

disabled and healthy individual.

NCIL supports the inclusion of references throughout the bill to ADA and Section 504 of the rehabilitation act, with regard to nondiscrimination. It ensures that peo-ple with disabilities are a protected class. Clearer statements in each section are necessary to assure compliance with those laws.

Quality assurances through the establishment of national standards, benefits and

access to be set by National Board with input from consumers

All Advisory boards under established under Title I should be required to include

as members people with disabilities.

Accountability to all consumers through the establishment of annual report card, national quality management provision operating at the national, regional alliance, state, plan and provider level to ensure "quality oversight."

Creates grievance procedures at the plan level, use of alternative dispute resolution, private right of action which includes compensatory and punitive damages and attorneys fees provided for against all entities established under legislation and sanctions included at federal, state and local levels such as decertification, federal assumption of responsibility and civil penalties.

Protections against catastrophic out-of-pocket costs by establishing limits on outof-pocket costs for deductibles and co-payments at \$1500 for an individual and

\$3000 for families.

Long term care package Recognition of the critical need for long term care program in health care reform for people with disabilities based on functional need rather than on income or age, and program must include at a minimum personal assistance services.

Requires states to honor consumer choice regarding services and providers to the

extent possible.

Allows tax credit for working individuals with disabilities who pay out-of-pocket for personal assistance services.

Concerns to be addressed

Through the direction of Congress the plan must contain a comprehensive benefits package that adequately addresses the needs of people with disabilities including re-habilitation therapies, and adequate durable medical equipment.

Requires states to establish and maintain advisory groups, a majority of whose members are individuals with disabilities or their representatives. NCIL applauds the steps taken in this are, but continues to advocate for more consumer control of the services to bed provided. NCIL recommends a change in the language to say "a majority of consumers and family members" as opposed to "their representatives." We have had many people such as Jerry Lewis who have claimed to be our representatives in the past. This is unacceptable language.

Develop a National Disability Advisory Board that reviews disability issues across

the entire spectrum of health care.

NCIL supports the concept of an "out of network" option, but we are concerned

about the cost, and who makes the choice for that option.

There should be assurances that gatekeepers for people with disabilities are specialists in that particular area, or that people with disabilities have access to out of network providers as gatekeepers without any financial disincentives. For a person who has quadripalegia, something as simple as antibiotics for a cold may have negative side effects on the functioning of their kidney. A primary care physician may not be aware of this.

Incentives for providers to serve a number of clients per month must not interfere with the rights of people to have adequate time with a provider to meet the unique needs of people with disabilities including people with mental retardation and other

cognitive disabilities.

Managed care systems must have adequate quality assurance mechanisms as well as effective grievance policies and procedures to address the needs of people with disabilities. Where there is clear discrimination, severe penalties should be imposed.

Specific explanation pertaining to the exclusion of individuals with birth defects and congenital disabilities in coverage of out-patient rehabilitation services. NCIL cannot and will not support any proposal that mandates unequal treatment for individuals with congenital and birth defects, such as forcing these individuals into a more costly benefit package in supplemental insurance.

Refinement of language in out-patient rehabilitation services to be inclusive of the critical need for people with disabilities with respect to coverage for the maintenance of functioning and prevention of deterioration of functioning in the acute care

benefit package.

Clarification of language pertaining to durable medical equipment to ensure that people with disabilities have access to devices, services and equipment needed con-

sistent with recent technological advances.

Clarification is warranted in the mental health coverage benefit package with regard to in and out patient coverage. NCIL is concerned with out of pocket expenses for further mental health coverage will not be applied to annual out of pocket expenses. NCIL is adamantly opposed to the disparate treatment of individuals with mental illness in the acute care package, especially with respect to the aforementioned.

NCIL is concerned that there is a lack of clarity around assistive technology both in the acute care section under DME and under the LTC section. For many people with disabilities, assistive technology is vital to their independent functioning.

During the transition phase of this proposal, assurances need to be in place so that people with disabilities will not lose coverage. Smaller companies may choose to drop people with disabilities because of real or assumed high costs. These people would then be forced to locate other plans until this plan takes effect. The result will be that many people with disabilities will be denied health care benefits during the transition period due to pre existing conditions or dramatically higher premiums, or both. There is also concern that people with disabilities on waiting lists for state medicaid waiver programs will be held hostage on those lists until the new waiver program which reimburses state at a higher rate goes into effect. There must be assurances that people with disabilities who receive, or will receive benefits through both the private and public sector are protected during this period.

Position on personal assistance services

NCIL, along with other national disability-related organizations including American Disabled for Attendant Programs Today (ADAPT), the World Institute on Disability (WID), and the Citizens Coalition on Disability (CCD), has been at the forefront in promoting the adoption of a national policy to establish a national Personal Assistance Services (PAS) program. NCIL and other groups committed to a national PAS program are firm in the belief that a national PAS program should have substantial input and influence from consumers of the service at the governance level and that a national PAS program should be consumer directed and controlled to facilitate the full implementation of the vision of the Americans with Disabilities Act of 1990.

Background on personal assistance services

Almost 7.7 million Americans require some assistance from another person with daily living tasks such as dressing, eating, toileting, housekeeping, remembering to take medications, balancing a checkbook, and other everyday activities, according to research conducted jointly by WID and Rutgers University. This assistance is called Personal Assistance Services. A study conducted by Families USA reports that 64% of people needing such assistance were not able to get it last year. National long term services policy is biased in favor of institutionalizing people who need such assistance rather than assisting them in their own homes and/or communities. This bias is reflected in the fact that the federal government spends 82% of federal long term services funds on nursing homes (\$28.4 billion), six times as much as on home and community based services (4.6 billion). In addition, states that receive Medicaid funding are required to finance nursing home confinement for low income people, but have no such requirement for financing home and community services for the millions of people with disabilities who could be active in their homes and communities with such assistance. As a matter of fact, a state must go through a difficult waiver process to get permission from the federal government in order to direct any of its Medicaid funding to home and community based services. Currently, many states that do have the waiver are cutting back home and community based services because of tight budgets. Stereotyping attitudes on the part of many people who cannot conceive of people with disabilities living in the community with Personal Assistance Services, along with powerful lobbying efforts by the \$60 billion nursing home industry, contribute to the perpetuation of this institutional bias.

NCIL position on personal assistance services

NCIL's basic position on Personal Assistance Services is that the institutional bias on the part of the federal government and state governments must be reversed and that people of all ages with all types of disabilities must have the option of obtaining assistance with daily living in their homes and communities through a national consumer controlled Personal Assistance Services program. In addition to cost savings, the dignity, quality of life, and productivity of people with disabilities would be enhanced. Americans with all types of disabilities and all citizens of the United States deserve no less.

NCIL believes that a national Personal Assistance Services program must have certain characteristics in order to most effectively and efficiently meet the needs of people with disabilities in their homes and communities. These characteristics are spelled out below and further delineate NCIL's position on Personal Assistant Serv-

ices.

#### Definition of PAS

Personal Assistance Services means assistance from another person or persons with tasks in the home or community which people with disabilities would typically be able to do for themselves if they did not have a disability and includes assistance with various types of cognitive, physical, mental and sensory tasks.

## Types of PAS

NCIL believes the following comprehensive range of Personal Assistance Services must be available for an effective, efficient PAS program:

Personal services including, but not limited to, assistance with bathing and personal hygiene (including menstrual care), bowel and bladder care (including catheterization), dressing and grooming, transferring, eating, medications and

injections, and operating respiratory equipment and other assistive devices.

Household services including, but not limited to, assistance with meal preparation, light and heavy cleaning, laundry, repairs, and maintenance.

Community services including, but not limited to, assistance with shopping, employment, education, participation in community and civic affairs, and lei-

Cognitive services including, but not limited to assistance with money management, scheduling, planning, cucing, and decision making.

Communication services including, but not limited to, interpreting, reading, and writing.

Mobility services in and out of the home including, but not limited to, escorting and driving.
Assistance with infant and child care.

Security- and safety-enhancing services including, but not limited to, assistance with monitoring alarms and arranging for periodic in-person or telephone contacts.

NCIL further believes that although many of these services do not meet the traditional definition of "medical necessity" and will not result in medical improvements to the disabling conditions, their provision is necessary for people with disabilities to maintain their health and to prevent secondary disabilities and illnesses.

#### Program models

Personal Assistance Services users must be able to freely choose from a range of PAS program models from a voucher or direct cash payment model in which consumers totally manage their own PAS without medical supervision and the necessity of a burdensome, costly administrative structure to a contract agency model in which the agency assumes varying degrees of responsibility for managing the PAS.

The PAS users choice, direction and control in selecting, training, scheduling and supervising their Personal Assistant(s) must be maximized in all manage-

ment options.

The PAS users choice, direction and control of administrative tasks including, but not limited to, determining pay rates, withholding taxes, and paying benefits must be maximized in all management options.

All models must be non-medicalized and community based to the extent pos-

sible.

State issues such as Medical and Nursing Practices Acts and Personal Assistant Registry Acts must be resolved so that health-related tasks such as medication dispensation and injection and catheterization can be performed by unlicensed Personal Assistants under the direct control and supervision of PAS users when that is the choice.

#### Coverage and eligibility

NCIL believes that PAS coverage must extend to people of all ages with all types of disabilities including cognitive, sensory, mental and physical disabilities and that eligibility criteria must not discriminate based on age, type of disability and/or any other factor unrelated to need. NCIL's position is that individuals must be eligible for a national PAS program if they experience a functional disability of a temporary or permanent nature resulting from injury, aging, disease or congenital condition which limits their ability to perform one or more of life's major activities including, but not limited to dressing, bathing, grooming, getting around both inside and outside the home, eating, preparing meals, shopping, cleaning house, communicating, understanding, controlling emotions, and performing cognitive tasks such as problem solving and processing information.

Eligibility criteria must be developed that do not exclude people based on age; type of disability; onset of disability such as congenital, injury, disease, or later age onset; and health, family status, race, national origin, cultural background, religion, gender, sexual preference and/or geography.

Eligibility criteria must not include disincentives for employment and/or mar-

riage.

Eligibility must not be based on income factors although cost sharing is acceptable based on a sliding income scale (see the section on Financial Considerations below).

No person must be forced into or kept in an institution because of the denial

#### Governance of a National PAS Program

NCIL believes that the views of PAS users must be paramount in the design, delivery, and evaluation of a national PAS program.

PAS users must be decisively and formally involved and represented at all levels of policy determination, planning, program design, and implementation of a national PAS program.

Any national and/or state governance mechanisms must include PAS users in

substantial decisionmaking roles.

Any national PAS program that gives states the flexibility to plan, design, and implement state PAS programs must require each state to: 1) develop a long range three to five year plan to be updated annually which delineates the state's PAS philosophy, program design, and implementation and evaluation plans, and 2) establish a policy board consisting of at least51% PAS users with a broad range of disabilities which has the authority to sign off on the required state plan and updates jointly with the lead agency. Such Policy board must be

independent of state agencies and must have adequate staff and budgets to carry out the assigned responsibilities.

NCIL believes that whatever national program design and funding mechanisms are employed, states should be required to adopt the definition and provide the basic services, program models, coverage and eligibility criteria, governance mechanisms, and grievance and appeal procedures cited in this position paper in order to provide uniform coverage for people with disabilities across the states. NCIL further believes that a gradual phase in of a PAS program would be in order that a PAS infrastructure can be developed to meet the demand.

### Financial considerations

NCIL believes that financing mechanisms and regulations for a national PAS program should in no way reflect a bias toward institutionalization and away from Home and Community Based Services.

Cost sharing and/or tax credits must be part of a national PAS plan based on a sliding scale relative to income, but with a cap on out-of-pocket consumer expenditures at a percentage of income and/or on tax credits. The families of children who receive PAS benefits must be treated the same as direct PAS users in terms of cost sharing and/or tax credits.

There must be no unfavorable differential federal match requirement relative

to any other long term service programs.

Any benefits, whether direct vouchers/cash or not, derived by PAS users must not be treated as disposable income nor counted as income for the determination of eligibility for other statutory benefits/services.

Federal and state governments must clarify tax withholding and Personal As-

sistant benefit requirements for PAS users and providers.

Long term services insurance reform should be undertaken in conjunction with a national PAS program which addresses standardized benefits packages and the elimination of pre-existing condition exclusions.

No one who receives PAS benefits at the time of adoption of a national PAS

program must lose the benefits they are receiving.

#### Appeal and grievance procedures

NCIL believes that a national PAS program must include a uniform appeal/grievance procedure independent of funders, providers, and assessors which has an expeditious time-line and which provides expenses for the use of advocates and/or legal

counsel by PAS applicants/users or their families.

In summary, a Health Care plan that is designed to meet the needs of people with disabilities is a plan that will meet the needs of all Americans at all stages of our lives. It will give us all equal access to the best health care in the world. A good health care program that is affordable, accessible and universal will carry on the promises of the American's with Disabilities Act and the Individuals with Disabilities Education Act. It will give people with disabilities the key to employment, to independent living and to freedom. Thank you, I will be happy to stand for questions.

## PREPARED STATEMENT OF LINDA M. LONG

The Ad Hoc Committee on Health Care Reform and Disability is a group of people with and without disabilities working to ensure universal right to health care which is meaningful for all citizens, including people with disabilities. I am here today to speak on behalf of the Committee to tell you that there is a health care crisis and to share our perspective on health care reform. As an attorney with the Disability Law Center in Boston, Massachusetts, I represent low-income people with a variety of disabilities, including developmental disabilities, to preserve their access to health care.

In Massachusetts, we have worked hard to create a reasonably good health care system and a strong disability rights movement. We have a Medicaid program which provides comprehensive benefits and other protections such as the hospital free care pool for people with low incomes. Massachusetts is the home of one of the oldest personal assistance programs in the country. Yet, there are

still many people who fall between the cracks, and those cracks are growing wider all the time. In my work, I see people who have worked very hard to put together a system of community supports which will enable them to live as independently as possible. Many of them are now threatened with the loss of these essential health care services because of the increasing pressure to cut our state Medicaid budgets and for a host of other reasons. I speak with many more people who do not have access to necessary health services, but for whom I can do nothing because the reasons they cannot get adequate health care are perfectly legal. People with disabilities have a lot to gain and a lot to lose in this health care debate, and I appreciate the opportunity to come and speak with you about this issue.

People with disabilities have made extraordinary strides toward inclusion and integration in the last 30 years. Laws such as P.L. 94-142, the Education of All Handicapped Children Act, Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act have all made a dramatic difference in our lives. The Co-chairs and the members of this Committee are to be thanked for your leadership on the Americans with Disabilities Act and the other pieces of legislation which have transformed the lives of people with disabilities.

The lack of a universal right to health care is one of the remaining barriers to full integration and productivity for all Americans, including people with disabilities and chronic conditions. Universal coverage as proposed by President Clinton and Hillary Rodham Clinton is an important step forward. The elimination of pre-existing condition exclusions, experience rating and other discriminatory practices would provide people with many more employment options. It would remove economic disincentives to work, making it possible for more people to take the risk of giving up their public benefits for competitive employment. Statistics show that most people with disabilities would eagerly seek gainful employment, if the economic, physical and attitudinal barriers were not so great.

Some refinements are still necessary to clarify the meaning of universal health care as it applies to people with disabilities and all people. The provision of adequate, affordable health care to people with disabilities is a litmus test which will demonstrate the effectiveness of health care delivery in general. If health care reform does not work for the people who most need health care, for whom will it be effective?

One of the most important things that the Clinton plan does to ensure universal coverage is to preserve the Medicaid program as a wrap around program which supplements the guaranteed benefits package for low income people. This measure represents a real commitment to health care access for low-income people, many of whom are people with disabilities.

Another major step forward and one of the fundamental reasons for support of the Clinton proposal among people with disabilities is the inclusion of a home and community based long-term care program for severely disabled individuals. Across the country, many people with disabilities remain institutionalized unnecessarily because of the lack of appropriate services, such as personal assistance services at home. They languish in nursing homes and hospitals, at great cost, only because that is the only setting in which they will receive help with such fundamental activities as getting out of bed in the morning. One of our ad-hoc committee members was kept in a county hospital for seven years for this very reason. The Clinton proposal's home and community based long-term care program is the first national proposal which

shows a real commitment to providing people with disabilities with services such as personal assistance services which make it possible to live full and productive lives in the community.

A fundamental issue of concern to people with disabilities is the arbitrary distinction often made in the health care debate between "acute" care and "long term" care. All health care is long term care. We all, regardless of our physical and mental capacities, need to take care of our health on a daily basis through a variety of means. We may not always do it, but we should. The way a person without a disability or chronic condition takes care of her health may be through exercise, a healthy diet and the avoidance of unhealthy habits. The way a person with a disability takes care of her health may include not only these means, but also ongoing respiratory therapy with periodic monitoring from a visiting nurse. Failing to provide these services on an ongoing basis could result in an acute crisis and greater costs in the long run.

Another related area of concern is the narrow interpretation given to the concept of "preventive" care. The term "preventive care" as applied to people with disabilities, includes ongoing services such as outpatient rehabilitation, outpatient services such psychotherapy and assistive technology to maintain function and prevent or minimize degeneration and serious, acute complications. A person with a disability has often had to work long and hard to attain the functional level she has and values that functional ability, whatever it may be, just as much as a person without a disability values her functional abilities. Therefore, the degeneration of one's condition or the onset of a secondary disability can be just as devastating to a person with a disability as the onset of a primary disability is to a non-disabled person. I can point to my own experience as one example to illustrate this point. I have a congenital disability by the name of spina bifida. This condition causes severe neurological and orthopedic damage. It is not curable, but its effects can be ameliorated. To make it possible for me to lead a productive life, I had 10 operations and countless hours of physical therapy when I was child. I spent a year in a rehabilitation facility at the age of three to learn how to walk with crutches and braces. Recently, at the age of 30, I began to experience intense pain in my right hip and lower back. I felt as though I was about to snap in half at the waist. I could barely function. The reason for this pain was primarily the natural process of aging with a disability. Without intervention, I would have been at serious risk of damage to the bones and nerves in my spinal column. I could have lost a great deal of my mobility and could have been forced to deal with chronic pain for the rest of my life. Through the use of orthotics and physical therapy, I have been able to alleviate this pain and maintain roughly my current level of functioning. After all of the effort that I have put into moving about as independently as possible, it means no less to me to lose my current abilities than it would for a person without a disability. When one has learned to live with a certain level of disability, it is very hard to lose ground, no matter what the starting point. We feel strongly that language regarding rehabilitation therapies must explicitly include maintenance of function. These services are preventive services for people with disabilities and are an essential part of any health plan.

Similarly, outpatient mental health services are an essential tool in preventing unnecessary psychiatric hospitalization for many people. One woman whom I know has successfully avoided hospitalization for years through her use of outpatient psychotherapy. She was born with severe cerebral palsy and was physically and emotionally abused as a child. Without warning, she can become absolutely panic-stricken at the slightest provocation.

She has frequent and serious thoughts of suicide. She receives one and one-half hours of psychotherapy per week. This woman consulted with me because she was concerned about potential cutbacks in service. I spoke with her and with her psychotherapist. Each told me independently that she was convinced that without this intensive outratient treatment, this woman would almost certainly have ended on a psychiatric hospital at greater cost. Commitment to a psychiatric hospital, a difficult experience for anyone, be even more traumatic for her because of potentially difficulty in finding a psychiatric hospital which accommodate her physical disability. Limits placed on outpatient mental health benefits may render them inadequate as a preventive measure for her and many people like her, resulting in costly and inappropriate hospitalizations. Greater reliance on outpatient treatment as a cost-effective preventive measure and mainstay for many people with chronic mental illness is necessary to adequately meet their needs. People with mental health issues should not be provided with treatment less adequate and less flexible than the treatment provided to people whose main concern is their physical health. Nor should they be required to pay more out of pocket for their care.

As people with disabilities have left the confines of homes and institutions over the last several years, modern technology has worked to ensure that assistive devices and services are available to replace functions which their bodies will not perform and make it possible to participate in our fast-moving world. technology can now provide assistance to people with a variety of disabilities. Durable medical equipment has now become more than a walker or hospital bed. One man who has a severe speech impairment uses an augmentative communication device called a Touch-Talker to replace his voice. He simply types out letters which appear on a small screen. Through the use of this device, he is able to communicate well enough to live on his own and attend college. Last year, he was voted President of his student council. All of this was accomplished without the need for invasive surgery to insert or attach any sort of device to the body. Similarly deaf and hard-of-hearing people rely on hearing aids and assistive listening devices to augment their ability to communicate. There is no difference between these sorts of assistive devices and a walker or a wheelchair. They simply replace different body functions. We support language which includes hearing aids and other assistive devices, regardless of which body function they replace. We should not be bound by outmoded definitions of durable medical equipment that were created twenty-five years ago and fail to reflect modern technological advances.

We believe it is key to include language ensuring that people with congenital conditions have access to services such as outpatient rehabilitation, home health care and extended care. Language which only makes these services available to those who experience an "illness or injury" after birth must be changed to provide individuals with congenital conditions an equal opportunity to preserve our functional capacities. Otherwise, we are left with a pre-existing condition exclusion specifically for people with congenital conditions. We see no rational basis for this distinction. Why should a child born with servebral peley receive less treatment than a child who has similar symptoms because of a head injury? Why should I, born with spina bifida, be treated any differently than someone with a spinal cord injury? Will people with congenital disabilities and our families be left to face impoverishment in order to pay for health care? If health care is to be truly universal than it cannot exclude people simply because of the timing of the onset of their disabilities. To do otherwise violates this principle of universality and flies in the face of years of public policy regarding people with disabilities and our families.

In Massachusetts, the Medicaid program recently instituted a program of mandatory managed care which includes people with disabilities. The program is still new and so it is difficult to reach definitive conclusions about its performance. It is only fair to say that so far, we have had mixed results. Although for some people, managed care has had some success in providing continuity of care, for others, it has disrupted longstanding relationships with health care professionals for arbitrary reasons. One man with muscular dystrophy had an ongoing relationship with a pulmonary specialist in Rhode Island. Because Massachusetts rules strictly limit the ability of a specialist to act as a primary care clinician and furthermore, impose geographical limitations, this man was unable to continue this relationship. The primary care clinician whom he chose from a list was unable to provide him with appropriate treatment.

A number of problems have arisen with the enrollment process. Much of the enrollment process has taken place through the mail. Many people have found it difficult to wade through the materials sent to them so that they can make an informed decision about the options presented to them. Even though health benefits managers are available for questions, many people cannot understand the materials well enough to know that they can call to ask for assistance. This is particularly true for people with cognitive disabilities, and people who are illiterate or have language or cultural barriers. A recent study by the Massachusetts Hospital Association demonstrates that emergency room use has actually risen among Medicaid recipients since the inception of managed care, in large part because of the confusion regarding the enrollment process. A managed care system must have a user-friendly enrollment process which takes into account that many people cannot understand or rely upon written information. There is no substitute for human contact.

Also, the incentives created in managed care make it difficult for providers to accommodate the needs of people with disabilities. A simple matter such as spending more time with a person who has a developmental disability to explain how to follow-up on treatment in terms she can understand may take more time than is usually allotted in a managed care system. Failing to adhere to such procedures can result in negative repercussions for a provider in some managed care systems. It is important to ensure that managed care providers are able to tailor their practices to the individual and not just treat her as a member of a diagnosis Reimbursement for time spent in case management is critical. will encourage providers to provide people who require more lab. intensive follow-up with the attention they need. An ombudsma. program may also be useful in providing some necessary safeguards. A simple and straightforward process for appealing decisions made by the health plan is also necessary. In any case, no matter how flexible a managed care system tries to be, it will be difficult to ensure that the needs of some people with complex disabilities such as HIV disease will be met because of the inherent structure of the system, its incentives and disincentives. For this reason, an affordable point of service option or a fee-for-service option is essential.

Affordability is one of our major concerns in the health care debate. A health plan which offers comprehensive services to a wide range of people, but is not affordable, is not universal. There is no way to separate the principle of universality from affordability for anyone. We feel particularly strongly about this issue because many people with disabilities have low incomes. Therefore, programs like point of service or fee-for-service options must contain subsidies to provide real access to the people who need them most. Similarly, copayments have proven to be

barriers to access for people with low incomes. They should be eliminated for low-income people and minimized for others.

An interesting and innovative program here in Massachusetts which contains lessons for national health reform is the CommonHealth program. The CommonHealth program is a state-funded program which enables children and certain adults with disabilities to buy a benefits package similar to Medicaid. For some individuals, CommonHealth acts as their primary insurer. For others, it is a wraparound program which supplements their primary insurance. CommonHealth is both comprehensive and affordable. No one need impoverish themselves to purchase CommonHealth. Premiums are based upon a sliding scale. Over and over, I have heard people with disabilities and family members talk about how CommonHealth has made a tremendous difference in their lives; how it enabled them to get the services they needed to return to work or keep disabled children at home. I do not recall ever having heard anyone complain about the premiums. It is an excellent example of a program which provides affordable, comprehensive, long-term coverage to people with disabilities without forcing them to impoverish themselves and results in much greater productivity and independence. We feel it is important to learn from this success and incorporate the positive aspects of the CommonHealth plan, such as the sliding scale premiums, into a national health care plan.

It is a great honor to appear before this Committee. It reinforces for me the importance of having input into the decisions that directly affect our lives; a principle that is one of the most fundamental premises of democracy. We hope that you will include provisions in your legislation to guarantee the participation of people with disabilities and others familiar with disability-related health care issues in the decisionmaking bodies which set health care policy and procedures in the years to come. Inclusion in these decisionmaking bodies is essential to ensure that the health care system will meet the needs of the people who most need health care.

Thank you for the opportunity to come and speak with you today. We hope that you will continue to work with us to ensure that this debate results in a right to health care which is truly universal.

## PREPARED STATEMENT OF JANET O'KEEFFE

The Consortium for Citizens with Disabilities (CCD) is a working coalition of over 100 national consumer, advocacy, provider and professional organizations, which advocates on behalf of people of all ages with physical and mental disabilities and their families. Since 1973, CCD has advocated for federal legislation, regulations, and funding to benefit people with disabilities. This testimony is presented on behalf of the undersigned members of CCD.

People with disabilities include individuals with physical and mental impairments, conditions or disorders, and people with acute or chronic illnesses, which impair their ability to function. The 49 million Americans with disabilities have an enormous stake in the current health care reform debate. Lack of adequate health care coverage is a critical issue for many persons with disabilities and chronic illnesses, who have experienced first hand the myriad problems with the current system.

The U.S. health care system provides high quality care, but it is overly expensive, often wasteful, and does not assure adequate health care coverage for all Americans. Escalating and uncontrolled costs make insurance unaffordable for an increasing number of Americans, and discriminatory practices by insurance companies exclude millions more Americans who need health care. Current health insurance is also biased towards acute care and fails to cover necessary services for persons with chronic illnesses and conditions. For many persons with disabilities, lack of access to comprehensive health care undermines the promise of the Americans with Disabilities Act for inclusion, independence and empowerment.

Persons with disabilities and chronic illnesses are disproportionately represented among both the uninsured and the under-insured in the current system of private health insurance. As it operates today, the U.S. health insurance system fails persons with disabilities and chronic conditions in fundamental ways:

- It excludes many persons with disabilities and chronic conditions as "medically uninsurable" or offers them insurance only with pre-existing condition exclusions. In a recent Census Bureau survey, 43 percent of persons with severe disabilities reported that they did not have private health insurance.
- It often charges prohibitive rates to persons with ongoing health needs, making insurance unaffordable for many.
- It does not pay for many necessary health-related services, including adequate rehabilitation, assistive technology, and long-term services and supports.
- It places annual and life-time limits on health care services.
- It often fails to provide protection against catastrophic health care costs.
- It allows insurers to terminate insurance coverage when a person becomes ill.

For all these reasons, CCD strongly endorses the need for far-reaching and comprehensive reform of the American health care system.

When evaluating the adequacy of a health system reform proposal, whether the needs of persons with disabilities and chronic illnesses are met is an essential litmus test. It is our strong belief that a health care system that meets the needs of persons with disabilities and chronic illnesses will meet the needs of all Americans.

We are here today to share with you our evaluation of the Health Security Act (HSA). To begin, we strongly commend President Clinton for introducing this legislation and for committing his Administration to ensuring comprehensive, affordable health coverage for every American. We also strongly support the Administration's proposal to expand home and community-based long-term services and supports for individuals with severe disabilities and commend him for recognizing the importance of including long-term services and supports as part of his health care reform effort.

#### POSITIVE FEATURES OF THE HEALTH SECURITY ACT

There are many positive features in the Health Security Act that address issues of concern to persons with disabilities. These features must be retained in any health reform legislation enacted by Congress. Legislative proposals that do not include these features do not constitute reform and will be vigorously opposed by the disability community. These fundamental features and the positive ways the Health Security Act addresses them are:

Universal Coverage. All legal residents of the United States will be covered by 1998 and health care coverage will not be dependent upon employment status, age, health, disability, or ability to pay.

Non-Discrimination. Federal civil rights laws, including Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, will govern all parts of the health care system, including health alliances, health plans, the National Health Board, and providers. These laws will provide important protections for persons with disabilities, including assurances that negative assumptions regarding the quality of life of individuals with disabilities will not be used to make determinations about the medical necessity and appropriateness of services. These protections are critical for persons with disabilities and must be retained in any health care reform legislation passed by the Congress.

Elimination of Pre-Existing Condition Exclusions. No one will be denied coverage for any health problem.

# Equitable Financing and Mechanisms to Spread Risk as Broadly as Possible.

- Mandatory community rating. Community rating is the cornerstone of equitable financing. It eliminates the exorbitant premiums that people with disabilities and chronic illnesses have been forced to pay for inadequate coverage. Community rating will also help to increase employment opportunities and ensure retention of employees with disabilities. Currently, many employers are unable to afford or obtain health insurance for employees who have a disability, or who have a family member with a disability or chronic illness. This situation discourages the employment of persons with disabilities.
- Mandatory Health Alliances. Community rating in a multi-payer system requires that risk pools be structured to spread the costs of heath care as broadly as possible. Therefore, we strongly support the requirement that all employers with fewer than 5000 employees be required to participate in the alliance. Without this level of participation, the risk and costs of health care will not be spread widely enough. Regional health alliances will enable small and medium size employers, the self-employed, and for-profit and non-profit organizations that employ people with disabilities, to benefit from the negotiating power of a large pool to obtain affordable, comprehensive coverage for their employees.

Exclusive, mandatory health alliances will require all residents in a geographic area to enroll in health plans offered through the alliance. This will assure portability of coverage. In our current system insurers pick and choose who they will cover, and employers often offer only one plan, which is not portable when people change their job. In marked contrast, requiring that everyone purchase insurance from a single alliance will assure that everyone can choose among a number of health plans, and keep their plan if they change or lose their job. Freedom of choice of health plans is particularly important for persons with disabilities and chronic illnesses who are Medicaid-eligible. Allowing persons who are Medicaid eligible to choose a health plan from those offered by the alliance will solve one of the major problems faced by Medicaid recipients in the current system: inadequate care due to a shortage of providers willing to accept Medicaid patients.

There are proposed alternatives to exclusive alliances, including a proposal to allow multiple alliances in a geographic area and the option for consumers to

purchase health insurance outside the alliance. CCD strongly opposes this proposal because it would perpetuate the current segmented health insurance market that fails to spread risk adequately. We are greatly concerned that allowing individuals and businesses to purchase insurance outside the alliance will allow insurers to continue skimming the low risks out of the population; this will drive up costs for the plans that enroll a broader cross mix of the population, which would include a larger proportion of persons who are high users of health care. A voluntary and competing alliance approach will only continue the current system where too many insurance companies compete in a segmented market, making it impossible to adequately spread risk. Additionally, it will reduce the state's ability to provide stringent oversight of both marketing practices and quality of care.

Subsidies for Small Businesses and Persons With Low Incomes. All
businesses will be able to deduct 100 percent of the cost of insurance as a
business expense. Additionally, small employers with low wage workers, and
individuals and families with low incomes will be eligible for subsidies for the
community-rated premiums. In addition, persons with low incomes will
receive cost-sharing discounts.

## The Elimination of Financial Barriers to Services.

- Elimination of lifetime caps on medically necessary or appropriate covered services. Persons with high ongoing health costs will be assured of coverage.
- Protection against catastrophic out-of-pocket costs. Deductibles and co-payments will be limited to \$1500 annually for an individual and \$3000 annually for a family. No balance billing will be allowed, i.e. providers will not be allowed to charge patients more than the amount negotiated with the health plan.

Comprehensive Benefits Package. Every American will have coverage for a specified, broad range of preventive, diagnostic, and treatment services. Many of these services are particularly important for persons with disabilities:

- Inpatient and outpatient rehabilitation services.
- Outpatient prescription drugs.
- Experimental treatments through approved clinical trials.
- · Preventive services.
- Mental health and substance abuse treatment services.
- Durable medical equipment, orthotics (orthopedic braces) and prosthetics (artificial limbs), and prosthetic devices that replace all or part of the function of an internal body organ.
- Home health and extended care services.

Funding for Long-Term Services. The proposal recognizes that long-term services are crucial components of health care for persons of all ages with disabilities and chronic illnesses, and must be included in any plan to reform the nation's health care system. While long-term services and supports are not included in the mandated benefits package, the Administration has proposed to expand the availability of these

services through a new program of home and community-based services, and to provide tax credits for personal assistance services for working persons with disabilities. Without these services, many individuals may be inappropriately institutionalized at a higher cost, both in economic and in human terms.

Chronic conditions account for 90 percent of all health problems. Chronic disease and illness are major causes of disability. The prevalence of functional impairments due to chronic illness, congenital conditions and trauma, has increased rapidly in the past decades and is expected to increase further in the coming years. This is due to advances in medical technology that save lives, but which often leave the survivor with significant disabilities. Yet, while treatment for acute episodes of care is covered, many persons with chronic illnesses cannot obtain the services they need to maintain their fragile margin of health. For these persons, it is not so easy to draw a clear line of distinction between acute and long-term services and the coordination of acute and long-term services is crucial.

Other people with disabilities need long-term services and supports to function independently. For many children and adults with disabilities, these services and supports can mean the difference between independence and dependence. CCD has several recommendations for refinements to the Long-Term Services provision of the Health Security Act, which we presented to the Committee in December 1993, and so we will not discuss them in this testimony.

The Incorporation of the Acute Portion of Medicaid into the New System. This step will eliminate the current two-tiered system of health care by providing every American with the same choice of health plans.

Cost Containment. The proposal includes measures to ensure that health insurance remains affordable. Without effective cost containment, increased costs will be shifted to consumers in the form of higher premiums, increased cost-sharing, and reduced benefits. Effective cost-containment measures include:

- Caps on premium increases.
- Competition among health plans in the regional health alliance.
- Standardization of health insurance forms to reduce administrative costs.
- Medicare prescription drug rebates.

Consumer Participation and Consumer Protections. The proposal includes a system of government and private oversight with enforcement procedures, including the appointment of an ombudsman at the regional alliance level. Other important provisions that will assure consumer involvement and protections are:

- A guarantee of due process rights with regard to benefit determinations, grievance procedures, and access to judicial review; provisions to protect the confidentiality of medical records and to assure access to regulatory proceedings.
- The establishment of regional health care alliances, which will increase the
  negotiating power of consumers, particularly small businesses and selfemployed individuals. The mandated participation of consumers in the
  governance and administration of the health alliances will help assure
  accountability and responsiveness to consumer concerns.

- Consumer choice will be assured. Consumers will not be restricted to the plan
  their employer selects, but will be allowed to choose among a range of plans
  that they can keep if they change jobs. All managed care plans will have an
  out-of-network option. Consumers will be able to enroll in and disenroll from
  plans during "open season" and for "cause."
- Administrative simplification will make it easier for consumers to understand their health care coverage and their rights.

Consumer Protections During the Transition to the New System. There are a number of provisions designed to ensure maintenance of current health care coverage and benefits during the transition period. These include: requirements to help preserve current coverage, restrictions on premium increases, limits on the duration of pre-existing condition exclusions, and a national transitional health insurance risk pool. These protections are essential for persons with disabilities and chronic illnesses who may lose their coverage during the transition period as the insurance industry consolidates.

Research Initiatives. The HSA includes new funding for health research focused on prevention and outcomes research, which we strongly support. Priority areas include child and adolescent health, birth defects, chronic disease and conditions, mental health, environmental health, substance abuse, and the development of functional measures.

# RECOMMENDED REFINEMENTS TO THE HEALTH SECURITY ACT

Legislation to address the major problems of access, cost, and quality for a large, heterogenous population will, of necessity, be complex and highly detailed. Provisions to reform financial, organizational, and service arrangements must take account of major variations in population density, ethnic composition, health infrastructure, and economic circumstances. In an undertaking of such enormous complexity and scope, there is a danger that the specialized needs of subgroups of persons with the most serious and disabling illnesses and conditions will not be understood and addressed.

To assure that a reformed health system will meet the specialized needs of persons with disabilities and chronic illnesses and conditions, CCD recommends several refinements to the provisions of the Administration's Health Security Act. It is important to note that while these recommendations relate specifically to the Health Security Act, many of the problems they address are not problems with the bill per se, but problems with the current health system that must be adequately addressed in any health reform legislation that the Congress enacts. At the same time, the positive aspects of the current system must be retained.

# I. Reducing Financial Incentives to Underserve

The continuation of a multi-payer system of health insurance as proposed in the Health Security Act will reduce the extent to which risk and associated health care costs are spread. Therefore, individual health insurance plans will continue to be at risk for insolvency if they incur catastrophic costs. This situation and the need to contain costs generally create a variety of financial incentives to underserve persons with extensive or special health care needs. These incentives exist throughout our current health care system but are particularly problematic in capitated managed care plans.

As an example, certain types of managed care plans place individual physicians at financial risk when they serve persons with a need for intensive, ongoing services. This is a problem particularly for non-salaried physicians who receive a capitated payment for each person enrolled. In one such plan, a family whose child was born with multiple disabilities had great difficulty finding a pediatrician in their health plan who was willing to accept the child as a patient, because the physicians stated they would lose money if they accepted responsibility for the child, because he would require too much care. Other managed care plans pose similar problems of access and under-service. Some managed care plans attempt to pass on risk to providers in the form of financial incentives that seem especially likely to lead to underservice. These include bonuses or penalties to providers related to meeting or exceeding utilization limits and policies requiring physicians to assume the cost of out-of-plan specialty care. A recent GAO report concluded that the more risk is shifted to physicians, the greater the potential for inappropriate reductions in services. Therefore, CCD RECOMMENDS:

 Contractual provisions in managed care plans that shift financial risk to physicians and other health care providers should be strictly prohibited.

## A. The Need for Risk Adjustment

The risk adjustment formula is critical in determining how much the alliance will pay to each plan. Plans that serve a higher number of high cost enrolees should receive more resources. While the Health Security Act includes provisions for risk-adjustment of premiums and capitated payments, it is the consensus of experts that current risk adjustment data and methodology do not permit accurate estimates of risk based on factors other than age. Therefore, CCD recommends:

- 1. There must be increased funding for rescarch on the factors associated with high levels of health care utilization. The findings of this research will greatly assist in the development of a risk adjustment formula. This research could be conducted by the National Health Board, the Agency for Health Care Policy and Research and the National Institute on Disability and Rehabilitation Research.
- 2. Different methods of risk adjustment should be considered. Given the nascent state of the risk adjustment field, it may be more appropriate to provide half of the risk adjustment payment at the time of enrollment, and the remainder only if the health plan documents higher utilization at the end of the year. This approach would guard against people being classified as "high users" solely because they have a disability. Health care utilization by persons with disabilities varies enormously yet insurance companies often assume that all persons with disabilities are "high cost." Once a pattern of higher utilization is established, the full risk adjustment amount could be paid prospectively.
- 3. In conjunction with the previous recommendation, health plans receiving risk adjustments prospectively must be required to collect data on the factors associated with high utilization. These data must be made available to the National Health Board to assist in the development of accurate risk adjustment. Accurate risk adjustment is essential to assure that there are no economic incentives for providers to underserve people with disabilities, and to guarantee that the amount, duration, scope, and quality of services delivered to people with disabilities are determined by their actual needs. The data collected must include information on the type of disability or chronic illness, and information about the type and severity of a person's functional limitations.

- 4. While we oppose placing physicians at financial risk, should such practices be allowed in managed care plans, then risk adjustment payments should be made to the physician who is responsible for the care of persons with severe and ongoing health needs, not to the health plan.
- 5. While accurate risk adjustment methods are being developed, there must be mandatory reinsurance requirements so that plans do not have an incentive to restrict services for persons who incur extremely high costs.
- 6. Persons with disabilities, parents of children with disabilities, and professionals with expertise in serving persons with disabilities should be represented on the Advisory Committee for the Risk Adjustment System.
- 7. The provisions of the bill regulating the marketing of health plans must be retained. If health plans are allowed to market only to low risk individuals, some plans will wind up with a disproportionate share of high-risk individuals.

#### B. The Need for Time-Intensive Services

Another incentive to underserve is related to the time-intensive treatment needs of some persons with disabilities. If providers are not adequately reimbursed for their time (e.g. volume and time-based services), particularly in non-salaried, capitated care, or fee-for service arrangements, or if salaried physicians are penalized for not seeing a set number of patients in a given time period, they may be reluctant to provide services to persons with particular disabilities who require more time-intensive service. For example, a gynecologist may be reluctant to treat women with severe cognitive impairments because they may require considerably more time than is usually allotted for a given procedure. While there has been no systematic research on this issue, there is a large amount of anecdotal evidence documenting the problem.

Managed care plans that specialize in the treatment of certain health conditions such as AIDS, report that they need to assign a far smaller caseload to individual physicians because persons with certain conditions need both more services, and more time-intensive services. This need has been recognized by the Physician Payment Review Commission (PPRC), which has proposed a plan to compensate doctors for the time they spend with persons who have disabilities. In its annual report to Congress in 1991, the PPRC endorsed the use of special modifier that would increase payment by a fixed percentage for visit with patients who have communication barriers, disabling cognitive or physical impairments, or an unusual need for counseling or coordination of care.

Risk adjustment formulas consider aggregate utilization and expense, but do not take account of the need for more time-intensive services by some persons with disabilities, who may or may not be high-users of care. *Therefore, CCD recommends:* 

- The presence of physical, mental, and communicative functional impairments must be added to the list of factors used to calculate risk adjustment formulas.
- 2. Reimbursement formulas for all health professionals must include adjustments that take into account the need for more time-intensive services by some persons with disabilities.

 Financial practices in managed care health plans that penalize physicians and other health providers for not seeing a pre-determined number of patients in a particular time period should be prohibited.

#### II. The Elimination of Financial Barriers to Care

CCD is concerned about the effect of price competition among health plans on the ability of persons with disabilities to have a meaningful choice of both health plans and providers. If insurance plans are going to compete on the basis of cost, then choice of insurance plans will, in part, be based on ability to pay. If persons will have to pay more to join fee-for-service plans and to utilize specialists outside of a managed care plan, then access to some specialists will be dependent on ability to pay. These costs may be prohibitive for many persons with disabilities, particularly when added to the costs of supplemental insurance for access to benefits beyond the federally guaranteed minimum. To address this problem, *CCD recommends that*:

Cost sharing provisions must include subsidies for all low income persons
with disabilities and chronic illnesses to join the plan that is best able to
meet their needs. This includes subsidies for premiums, deductibles, and copayments. Additionally, there must be lower limits on allowable out-ofpocket costs for persons with low incomes.

The plan provides for reductions in cost-sharing for low-income families, i.e. for families with adjusted gross incomes below 150 percent of the applicable poverty level. *CCD RECOMMENDS*:

 When determining adjusted gross income, disability-related expenses should be an allowable deduction.

## III. Comprehensive Benefits

In the health care reform debate, the question of which services to include in the mandated benefits package is a critical one for persons with disabilities. The opponents of comprehensive reform insist that any mandated benefits package should be kept to a bare minimum and that people shouldn't be "forced to buy benefits they don't need or want." This attitude is short-sighted in the extreme. No one is able to predict what health services they will need in the future. No one can say with any certainty that they will never be in a major accident, will never develop a chronic illness, will never have a child, spouse, or sibling with a chronic health condition or disability. Often, those most at risk for these conditions believe they are at low risk and so would be unlikely to purchase a policy with adequate benefits if they were given a choice. For example, young men in their twenties are the population group at highest risk for traumatic brain injury, yet this group comprises a large percentage of the uninsured.

While a great deal of attention has been given to the 37 million Americans without insurance, there are also millions who are under-insured. The Office of Technology Assessment estimates there are between 38 million and 55 million persons under age 65 years of age who are under-insured. Under-insurance is the result of several factors, including: (1) lack of coverage for pre-existing conditions, (2) exclusion from coverage of certain categories of health care and related services, including preventive and diagnostic services, prescription drugs, extended rehabilitation, durable medical equipment, orthotics and prosthetics, assistive technology, and long-term care, (3) annual and lifetime caps and high copayments for certain conditions or treatments,

most usually for mental health and substance abuse services, (4) no limits on out-of-pocket payments for covered services, (5) no limits on expenses that exceed "usual, customary and reasonable" charges for covered benefits, and (6) a host of other exclusions based on restricted definitions of "medical necessity," or arbitrary limitations on services, such as rehabilitation. As a result, many families with insurance are faced with financial ruin in the event of a catastrophic illness or accident. In one study of uncompensated hospital care, 47 percent of the 1689 patients who incurred uncompensated costs had health insurance.

These limitations in coverage are often not apparent until a person becomes seriously ill. Consequently, most Americans report high levels of satisfaction with their current health insurance coverage. It is only when people experience a catastrophic illness or accident that requires a wide range of ongoing medical, rehabilitative and support services, that they discover just how few services their policies cover. They also find out that hospital and physician charges that the insurer determines are above "usual, customary, and reasonable" charges, are neither paid by the insurer nor applied to the out-of-pocket limits. Thus, out-of-pocket expenses are often far higher than stated limits. Additionally, many insurance plans nominally include a particular benefit, but the services covered are so limited that they are often insufficient in relation to their needs.

As an example, an HMO typically covers 60 days of rehabilitation, but a person with a severe stroke, a spinal cord injury, or a traumatic brain injury may require intensive rehabilitation for six months or longer, and intermittent maintenance or preventive services for another six to twelve months or for an even longer period. Persons with serious mental illness generally exhaust their inpatient lifetime mental health benefit within a year. Health insurance also rarely, if ever, covers long-term care, services and supports.

The mandated benefit package in the Health Security Act includes many services that are essential for persons with disabilities and chronic, disabling illnesses. The limitations on the scope, duration, and indications for these benefits must be clearly be consistent with what people need and are currently receiving.

There are several issues related to the mandated benefit package in the Health Security Act that require clarifications and changes. These will be discussed below.

# A. Outpatient Rehabilitation

Rehabilitation services are indispensable for persons who have experienced a loss or attenuation of physical, mental or communicative functioning as the result of a genetic condition, a congenital disorder or condition, a developmental condition, a disease, an illness or an accident. Rehabilitation is an essential component of the treatment of all these conditions. Additionally, just as primary preventive services like immunizations prevent the incidence of costly disease, secondary preventive services like rehabilitation prevent the incidence of numerous health problems and disabilities. If rehabilitation services to maintain function and to prevent deterioration are not adequately covered, children and adults with disabilities will be at risk for deterioration in their functional status and for the development of complications.

It is irrational to use heroic methods to prevent death and then ignore the need to prevent the complications of chronic illness and the development of secondary disabilities. These conditions lead to higher acute costs over time. Given these inevitable costs, the provision of comprehensive rehabilitation services to persons with disabilities is a rational approach to ensuring system-wide cost reductions by preventing expensive complications. Rehabilitation services also increase individual functioning and productivity.

Section 1123 covers outpatient rehabilitation services such as Physical Therapy, Occupational Therapy, and Speech Therapy, but only when they are provided "to restore functional capacity or to minimize limitations on physical and cognitive functions as a result of an illness or injury." This provision is unduly restrictive for three reasons.

(1) The requirement in Section 1123 that rehabilitation services be available only to persons whose need for services results from illness or injury, effectively excludes persons with congenital, developmental and other conditions from receiving services.

The effect of this provision is to perpetuate a pre-existing condition exclusion for persons with congenital conditions, i.e. conditions that are present at birth. It makes an arbitrary distinction between those born with a disability and those who acquire a disability after birth, even if it is only weeks after birth. For example, under this provision, a child who develops meningitis (an infection of the brain) hours after birth and develops cerebral palsy would be able to receive these services, but a child born with cerebral palsy would not. This is discriminatory and unacceptable policy. To correct this problem CCD RECOMMENDS:

- 1. The phrase "illness or injury" must be replaced by the phrase "illness, injury, disorder, or other health condition." This language is consistent with language in the Health Security Act pertaining to the development of practice guidelines. It is also consistent in its effect with language in many current private insurance policies.
- (2) The requirement that rehabilitation services be provided to restore functioning and to minimize limitations on physical and cognitive functions must be interpreted to encompass medically necessary and appropriate prevention and maintenance.

While payment for services designed to maintain function or to prevent or minimize deterioration is provided under current public and private insurance, it is not clear that these services would be covered using the proposed language. Services required to maintain functioning or to prevent or minimize deterioration can be critical to preventing secondary disabilities or exacerbations of conditions. Without therapy, many individuals may lose the little functioning they have. For example, without maintenance physical therapy, a child with cerebral palsy could develop a dislocation of the hip, resulting in a need for expensive surgery and hospitalization.

The standard for re-evaluation in the bill uses improved function as the sole criteria. Maintenance and prevention are also appropriate standards for continuation. Therefore, CCD RECOMMENDS:

- Indications for outpatient rehabilitation services should also include maintenance of functioning and the prevention of deterioration.
- (3) The definition of outpatient rehabilitation services fails to recognize the full range of services covered under public and private insurance.

Rehabilitation comprises a range of skilled services provided to individuals in order to minimize physical, cognitive and emotional impairments, and to restore or maximize functional capacity. The full recovery of persons with catastrophic illnesses, injuries and conditions is dependent on the provision of

these services. Similarly, individuals with congenital conditions need these services both to attain their full functional capacity and to maintain that capacity. In addition to the three therapies listed in Section 1123, rehabilitation services also include a range of other services, including: respiratory therapy; audiology services (including hearing tests); speech-language pathology services for speech or language problems, augmentative communication and feeding and swallowing problems; cognitive therapies; orientation and mobility training for persons with severe visual impairments; and therapeutic recreation. Additional rehabilitation services currently covered by Medicare when provided in a comprehensive outpatient rehabilitation facility (CORF) include: psychological counseling, nursing services, and social services. Therefore, CCD RECOMMENDS:

- The full range of outpatient rehabilitation services, as enumerated above, should be included in the mandated benefits package.
- B. Durable Medical Equipment (DME) and Orthotics and Prosthetics (O&P)

Durable medical equipment (DME) includes such items as wheelchairs, crutches, hospital beds for use in the home, oxygen equipment, and a wide variety of devices that assist people with disabilities and chronic illnesses. Orthotics are orthopedic braces for the arms, legs, back and neck. Prosthetics are artificial arms, legs, and eyes, while prosthetic devices include devices such as hip replacement components and colostomy devices.

CCD is concerned that the definition of DME in the Health Security Act references the overly restrictive, acute-care oriented definition currently used in Medicare. This definition was formulated in 1965 when Medicare was enacted and reflects an outdated orientation towards persons with disabilities as homebound and dependent. This perception of people with disabilities is very different from that embodied in the Americans with Disabilities Act. Therefore, the durable medical equipment benefit within the Health Security Act should be refined to appropriately reflect the needs of people of all ages with disabilities and chronic illnesses.

Currently, there are a number of DME items not covered or otherwise reimbursable under the Medicare program because the item does not meet all the requirements of the four-part test Medicare has established to determine coverage. Even though such items may have significant therapeutic benefit for particular individuals under specific circumstances, they are considered to be "presumptively nonmedical" by Medicare. The rigidity of the four-part test has resulted in the denial of Medicare beneficiary access to a number of DME items that could maintain and/or improve the health status of millions of older Americans and Americans with disabilities, as well as prevent injury.

#### CCD RECOMMENDS:

Some items not currently covered and reimbursable by Medicare should be covered and reimbursable under the Health Security Act and any comprehensive health care reform proposal. These items include, but are not limited to: bath tub lifts and seats; bed baths; bed lifters; dehumidifiers and humidifiers; grab bars; hygiene items (i.e., incontinent pads, irrigating kits); portable whirlpool pumps; raised toilet seats; staircase rail(s); white canes; and air conditioners. These items are relatively inexpensive and may have significant therapeutic benefit for particular individuals under specific circumstances. Coverage and payment for these DME items, in the long run, may save substantial expenditures otherwise spent on more costly corrective therapies and items.

CCD strongly supports the Health Security Act's definition of "prosthetic devices," which reflects technological advances that have been incorporated into contemporary practice by health care professionals. The bill incorporates a functional test, specifying that "prosthetic devices" are covered not just if they replace the body member itself, but if they "replace all or part of the function of an internal body organ."

This language recognizes that prosthetic devices include devices that are surgically inserted. An example of such a device would be a pacemaker. It also recognizes that prosthetic devices include devices that are physically attached to the body, such as colostomy bags and supplies directly related to colostomy care.

Technological advances are enabling health care professionals to prescribe devices that replace all or part of the function of an internal body organ without surgically inserting or physically attaching the device to the body. We are pleased that by including a "functional" definition, the bill recognizes that prosthetic devices include assistive technology devices and other external devices such as augmentative communication devices.

Augmentative communication devices replace all or part of the malfunctioning or non-functioning element of the body's oral motor mechanisms, consisting of the speech center of the brain as well as the nerves, muscles, and organs that together control the production of speech and improve the functions of speaking for individuals whose oral motor mechanisms do not work. Obviously, "improving functional ability" includes improving the ability to speak; otherwise, Medicare and private insurance policies would not pay for an artificial larynx for this purpose.

The use of this contemporary "functional" definition of prosthetic devices will enable people who require augmentative communication devices for effective communication to receive them. Too often, under the current system, augmentative communication devices are covered only for persons who have had their larynx surgically removed.

CCD recognizes that coverage for such external devices is subject to the general policy that all devices provided under the comprehensive benefits package must be prescribed by a qualified health care professional within the scope of the professional's practice and must be medically necessary or appropriate.

CCD also supports the inclusion of assistive technology devices as authorized expenditures under the Health Security Act's new long-term services formula grant program for home and community-based services. The availability of these devices through the long-term services program will enable individuals for whom such devices are not otherwise covered under the comprehensive benefits package to obtain needed services. We believe that eventually the false dichotomy between acute and long-term care must be eliminated.

The Health Security Act's current language on durable medical equipment, orthotics and prosthetics, and prosthetic devices must be clarified so that it is consistent with private insurance coverage and Medicare policy. CCD's RECOMMENDATIONS to do this are as follows:

- Clarify that accessories and supplies used directly with these devices to achieve the therapeutic benefits and proper functioning of such equipment or devices are covered.
- Clarify that the replacement of such equipment and devices is covered, not only for a change in a person's condition but also in cases of loss, irreparable damage, and wear.

3. Clarify that repairs and maintenance of durable medical equipment, orthotics and prosthetics, and prosthetic devices are covered, as are fitting and training for the use of these items. These clarifications merely codify current Medicare policy and the policy of most private insurers with respect to coverage of accessories and supplies, repair and replacement, maintenance, and fitting and training, and will not add additional costs to the benefit package.

Finally, the bill specifies that an item or service is covered only if it "improves functional ability or prevents further deterioration in function." *CCD RECOMMENDS*:

- Items or services should also be covered if they will "minimize" further
  deterioration in function. This language is consistent with the purpose of the
  covered devices and equipment and conforms the provision to the language in
  the section of the bill pertaining to outpatient rehabilitation therapies. We
  believe that providing services to minimize deterioration will be cost-effective.
- There should be no arbitrary distinctions in the DME and O & P benefit that
  prevent people with disabilities and chronic disabling illnesses from receiving
  the health care services they need to function independently.
- The definition of durable medical equipment in the final legislation should be broader than the current Medicare definition, which is overly restrictive and does not take account of many of the needs of younger persons with disabilities.

# **Hearing Aids**

Hearing aids are prosthetic devices but they are explicitly excluded from the mandated benefits package. If surgery for a cochlear implant to improve hearing is a covered benefit, why aren't hearing aids to improve hearing also covered? The importance of hearing aids for children with severe hearing loss cannot be overestimated. The ability to hear and understand speech is crucial for language development in young children. If high cost and inappropriate utilization are a concern, at the very least, hearing aids should be provided to children who have a hearing impairment that interferes with their ability to understand speech. It is virtually certain that hearing aids will not be prescribed for children unless they need them. Therefore, CCD RECOMMENDS:

1. Hearing aids for children, at a minimum, MUST be covered.

# Disposable Medical Supplies

There is no mention in the mandated benefits package of disposable medical supplies. This category includes such items as surgical dressings, and catheterization and tracheostomy supplies, which are currently covered under Medicare and many private health plans. Such supplies are very cost-effective because they prevent infections, which are potentially life threatening. It is also not clear whether syringes will be covered for persons who need them for injectable medications, e.g. insulin for persons with diabetes.

#### CCD RECOMMENDS:

 Disposable medical supplies, including syringes, should be covered when medically necessary.

## D. Extended Care and Home Health Services

The indications for extended care and home health services are similar to those used for the outpatient rehabilitation benefit and are equally problematic. As written, these services will only be available for persons whose need for services results from illness or injury. As in the outpatient rehabilitation benefit, this provision effectively excludes persons with congenital, developmental, and other conditions from receiving services.

As noted earlier, the effect of this provision is to perpetuate a pre-existing condition exclusion for persons with congenital conditions, i.e. conditions that are present at birth. It makes an arbitrary distinction between those born with a disability and those who acquire a disability after birth. *Therefore, CCD RECOMMENDS:* 

- The phrase "illness or injury" must be replaced by the phrase "illness, injury, disorder, or other health condition."
- The full range of outpatient treatment and rehabilitation services, including respiratory therapy, should be available under the Extended Care and Home Care benefit.

# E. Prescription Drugs

#### (1) Formularies

Overly restrictive prescription drug formularies could have a detrimental effect on the quality of care for some persons with special medication needs. This is a particularly important issue for people with rare disorders, and people with low incidence and prevalence conditions. For persons with these conditions, there may be only one available drug treatment, and this drug may not be included in a formulary, or may be prescribed for an "off label" purpose. Access to the entire range of available pharmaceuticals is also critical for persons with conditions such as epilepsy, where treatment is highly individualized and persons may need to try a number of different drugs in varying combinations prescribed by their physician in order to achieve effective control of their seizures. *Therefore, CCD RECOMMENDS*:

1. Minimum standards for the operation of prescription drug formularies must be established to ensure appropriate access to medically necessary medications. At a minimum, the standards should include those set out in Section 1927(d) of Title XIX. In addition, access to medications not on the formulary should be guaranteed through a prior authorization process when justified by medical necessity. A plan's prior authorization process should ensure a response within 24 hours, and the provision of a 72 hour emergency supply of a drug when medically necessary as required in current Medicaid law.

#### (2) Generic Drugs

While the use of generic drugs should be encouraged as a way to control the costs of prescription drugs, for certain conditions such as epilepsy, the mandatory substitution of generic drugs without the informed consent of the consumer and the treating physician could severely compromise the effectiveness of treatment. There may be significant differences between the

characteristics of a brand name and a generic anti-seizure medication, as well as differences among different generic anti-seizure drugs. In some individuals, these differences could result in adverse effects, including a loss of seizure control and the development of toxic side-effects. *Therefore, CCD RECOMMENDS*:

 Health plans should not be allowed to substitute generic drugs for prescribed medications, without the informed consent of the consumer and the treating physician.

#### F. Mental Health and Substance Abuse Services

The mental health and substance abuse services are extremely limited in scope and duration and will be inadequate to meet the needs of persons with serious and persistent mental illness, and persons with psychiatric disabilities. Benefit caps for both intensive nonresidential services, inpatient and residential services are so inadequate that they will lead to severe service fragmentation, unnecessarily restrictive care, poor outcomes and higher costs. We strongly support the planned expansion of benefits in the year 2001, which offers fully comprehensive and flexible benefits, but have major concerns about how persons with psychiatric disabilities and persons with drug dependencies will receive the services they need prior to that time.

Services that are particularly important for people with disabling mental illness include in-home services, case management, partial hospitalization, psychiatric rehabilitation and other intensive, non-residential services (INR). INR services are essential for children with serious emotional disturbances, who should be provided treatment in non-residential settings whenever possible, so that they are not separated from their families. INR services have also been demonstrated to be both cost-effective and more acceptable to consumers of care than 24-hour residential placements.

These services are severely limited under the standard mental health benefit during the period 1998-2001. In addition to inadequate benefits, the higher cost-sharing requirements for mental health services are a major problem for persons with disabling mental illness, particularly since individuals with disabling mental illnesses often require a high volume of services. It is not uncommon for individuals with disabling mental illness to require daily rehabilitation and medication services. High cost-sharing is a major barrier to care because persons with disabling mental illnesses generally have low-incomes resulting from their inability to work. Many are unable to meet any cost-sharing requirements. To address the serious deficiencies in the mental health benefit, CCD RECOMMENDS:

- The elimination of arbitrary restrictions on the amount, duration and scope of services.
- 2. The discriminatory cost-sharing requirements for mental health services must be eliminated for those who cannot reasonably be expected to meet them.
- Cost-sharing for mental health services must be counted toward the out-ofpocket limit on an individual's annual health expenditures.
- 4. Persons with disabling mental illness who are Medicaid eligible must continue to receive optional Medicaid benefits such as rehabilitation, clinic services and case management. Given the major deficiencies in the proposed mental health benefit, the continuation of these services is essential.

#### IV. Extra-Contractual Services

Currently, some private insurance policies will pay for services not specifically included in the plan, i.e. extra-contractual services, in order to improve the quality of life of a beneficiary and to save money for the insurer over the long-term. For example, Aetna paid to retrofit an individual's house to make it accessible because it cost less to provide services in the home than in a hospital or rehabilitation facility. There is some concern that the language in the Health Security Act related to duplication of benefits in supplemental insurance may limit or prohibit the provision of extra-contractual services by insurance plans offering the mandated benefit package. Therefore, CCD RECOMMENDS:

- 1. Health plans should be allowed to offer extra-contractual services at their discretion, whenever they will result in an improvement in the beneficiary's quality of life and a cost saving to the health plan.
- V. Services for Children with Special Health Care Needs Under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT)

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) mandates under Medicaid require that children up to their twenty-first birthday are eligible to receive services for the detection and treatment of health conditions, developmental, mental and emotional problems and disabilities. In OBRA 1989, Congress strengthened the protections for children under this program to assure that they receive all the treatment services they need irrespective of any limits in a state's Medicaid plan. This gave children a right to necessary and appropriate services for which the federal and state governments would pay under the existing Medicaid matching formula. Eligibility for EPSDT is, of course, dependent on Medicaid eligibility which can vary by state.

Under current EPSDT law, states are mandated to pay for a wide range of community-based health and mental health services. As a result of the OBRA 1989 expansions, the benefits provided through the EPSDT program are more comprehensive in both scope, amount, and duration than those in the currently proposed basic benefits package. Some of these services may be available under the Administration's proposed long-term services benefit. Services currently provided under the EPSDT mandate include:

- Rehabilitation, including physical, cognitive, psychiatric, psychological, behavioral and other services, e.g. physical therapy, occupational therapy, speech-language pathology and audiology services, psychological and social work services;
- Clinic services for both physical and mental conditions;
- Assistive technology and equipment;
- Targeted case management, which includes the coordination of services, facilitation of access to various benefit programs, and intensive case management services for those with complex or extensive needs;
- Personal care services, including attendant care; and
- Hearing aids.

These services are critical to the full health and functioning of children eligible for

Medicaid and for all children. It is by no means certain that the federal regulations governing the new program proposed in the Health Security Act will include this wide range of services that children now have access to through many state Medicaid EPSDT programs, nor does the bill clarify whether any limits will be allowed on the scope, amount, and duration of services.

The proposals in the Health Security Act for children under Medicaid beginning with Sec. 4221, et seq., are very confusing. It appears that all children currently eligible for Medicaid, (with the exception of "Katie Beckett" children as authorized by TEFRA 134), continue their eligibility for benefits not included in the comprehensive benefit package. However, it appears that children will be eligible for different service packages, depending on how they become eligible for Medicaid. There may also be differences in the funding streams, payment mechanisms and points of access between children. Difference in these areas may result in significant negative consequences for children and their families. Moreover, children who live in low-income households will be eligible for a more comprehensive set of services than children who live in non-low-income households. In the latter situation, families could only obtain such services by paying the full cost. This new "two-tiered" system is totally inconsistent with some of the President's overarching principles for health care reform.

Under Sec. 4222 of the Health Security Act, low-income children who meet the eligibility criteria under current Medicaid law would be provided additional "supplemental" services under a new, fully-federally financed program modeled upon the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) mandate of Medicaid. The legislation does not provide details of this program but directs the Secretary of HHS to issue regulations on how the program is to be administered no later than July 1, 1995. The Administration has estimated that this program will be allocated \$9.8 billion over five years, beginning with \$264 million in FY 1996. Although annual appropriations are envisioned to increase to \$3.2 billion in the year 2000, these figures suggest a very limited program.

This "supplemental" program in Sec. 4222 would provide one hundred percent federal funding for items and services in Section 1905 (a), including also Section 1905 (r), of Title XIX of the Social Security Act, which are not included in the HSA mandated benefits package. The items and services listed in Section 1905 are identical to the current array of EPSDT mandated services.

Sec. 4221 indicates that no change is made in eligibility for Medicaid services; we infer from this that for cash assistance recipient children (AFDC and SSI), the federal government will continue to match, on the basis of an open-ended entitlement, state funds for all reimbursable services for which the state generates its matching funds. To further confuse the issue, the eligibility for the new program under Sec. 4222 clearly includes children on cash assistance programs (SSI and AFDC).

If this new "supplemental" program in Section 4222 will provide funding for the items and services in Section 1905 that are not included in the mandated benefits package, for both cash-assistance and non-cash assistance children, we are concerned that the program is underfunded. But if the language in Section 4221 means that states will continue to be responsible, under existing federal/state matching requirements for all services for children on AFDC and SSI as mandated in OBRA 1989, then it appears that they will not be funded through the new program in Section 4222. If this is correct, then the amount allocated for the new program would not fall quite so short of the need.

The Administration's proposal sets the new program's base at FY 1993 spending levels. Implementation of the EPSDT mandate, including expansions in OBRA 1989. is currently very uneven among the states. Few states have conducted appropriate outreach to low-income families, and as a result, many of the children who should have access to full and comprehensive benefits under EPSDT have not been identified. The Health Care Financing Administration reports that in FY 1993, the year for which the Health Security Act caps the federal contribution, only 41 percent of all children eligible for EPSDT had been enrolled by the states. A number of states, however, have recently put together comprehensive, prevention focused, statewide initiatives. Kansas (Kan-B-Healthy), North Carolina (Healthy Children and Teens), Oklahoma (Sooner Start), Wisconsin (Healthcheck) and other states are attempting to fully implement EPSDT. However, these initiatives are all relatively new and have reached only a limited number of the children they are targeting and so current spending is substantially below what is needed. Also many Medicaid families are unaware of their entitlement to services not included in the state's overall Medicaid plan and thus are not accessing the full range of services to which they are entitled. Providers, too, are ignorant of the extent to which they could lawfully provide medically necessary and appropriate reimbursable services to these children.

The Administration also has not taken account of the enormous variability in state spending on EPSDT services. This raises many questions that must be answered. How will the new program compensate for the lack of appropriate EPSDT programming in many states? How will federal resources be allocated with this existing disparity? The comprehensive of the benefits and the integrity of the service and support systems in place must be maintained, but mechanisms and supports for improvements must be made available where necessary.

It is also essential that provider reimbursement for all covered services be adequate. Otherwise, children may suffer as they do now in having access only to those providers who will accept low reimbursement rates. In addition, if states are not required to raise their Medicaid reimbursement rates for the services in Section 4221 and 4222 so that they are compatible with provider rates paid by health plans, we could well see the continuation of a "two-tiered" system. For many children, this would mean continued financial barriers to services because no providers will accept these lower rates.

We are pleased to see that the Administration has recognized the importance of the wide array of services provided under the EPSDT mandate for children. However, it is disturbing that the proposal suggested to replace the EPSDT mandate is so unclear, undefined and, we believe, underfunded. It is unclear why this proposal, which could drastically change and perhaps endanger the EPSDT mandate, has been offered at the same time that the Administration promulgated a notice of proposed rulemaking to further the implementation of the EPSDT mandate on October 1, 1993. The confusion over financing is compounded by the description in Secs. 9001, 9002, 9011 and 9012, which describe state payments to the health alliances. These payments will affect the availability of services as well as the availability of other state resources for other Medicaid-reimbursable services that are not included in the basic benefit package, i.e., mandated and optional Medicaid services which are not provided by health plans, e.g. services provided under the Individuals with Disabilities Education Act (IDEA).

All of these funding issues are compounded by the unclear relationship to the state maintenance of effort payments and the cash assistance payments to the health alliances. The Medicare Catastrophic Amendments of 1988 authorized state Medicaid agencies to receive federal reimbursement for special education related services contained in a student's Individualized Education Plan under the Individuals with

Education Act and early intervention services included in an Individual Family Services Plan under Part H of IDEA. As a result, most state Medicaid agencies are now allowing school districts and early intervention providers to obtain reimbursement for services provided. The state match for the federal Medicaid funds is often provided either by the local education agency or a state general fund match from the lead agency for early intervention. Many states' programs and services under IDEA have become dependent on this important source of funding during the last six years. The President's proposal is unclear about the future of this important source of funding to support critical school and early intervention services.

In any new proposal to fund these critical services, the relationship of any services funded under any "supplemental" program to services provide though health plans, services provided in schools (especially those provided under IDEA, and other health services must be considered. Such coordination will assure that children get all the services they need in an appropriate manner. Such integration will also streamline access for families.

To fulfill the promise of the EPSDT mandate, a comprehensive benefit package must be available to assure the health and optimal functioning of all children. Therefore, CCD STRONGLY RECOMMENDS:

- 1. The Medicaid EPSDT mandate should be continued with the current eligibility criteria, including the criteria for children eligible under the "Katie Beckett" TEFRA 134 provisions. This will ensure that no children will lose any health care they now have, as they Administration has promised.
- A comparable "supplemental" benefits package funded by the states in partnership with the federal government should be provided to all children. This program should be affordable and have a cap on out-of-pocket costs based on family income.

Early identification of disabilities and health needs and the subsequent provision of necessary treatment for all conditions are critically important as Congress recognized in 1989 when it strengthened the EPSDT mandate. However, the Administration's proposal to develop a fully federally-funded "supplemental" program does not provide assurances that the full range of EPSDT services currently available under Medicaid will continue to be available. Therefore, CCD RECOMMENDS:

- 1. The financing must be adequate to meet the treatment needs of children. State participation should be considered.
- 2. The provisions of any "supplemental" program, whether its Medicaid or non-Medicaid funded, must be clarified and better articulated in the legislative language, especially with regard to state maintenance of effort, integration with the Alliances and Health Plans, and relationship to other programs and funding streams.

# VI. Continued Availability of Services Currently Received Through Medicaid

While we applaud the integration of Medicaid beneficiaries into the alliances for acute care services — a strategy which will help to eliminate the current two-tiered nature of our health system — Medicaid-eligible individuals must be assured a real choice among the full range of health plans. Individuals with disabilities or chronic health conditions may need to choose a high-cost plan because of its range of

specialists or relationship to a center of excellence. Low-income persons whose health needs require extensive specialty care will need a subsidy in order to afford a fee-for-service option or point-of-service options in managed care plans. A subsidy to purchase fee-for-service plans during the transition period was included in the Administration's September 7 draft, in recognition of the fact that many primary care providers — and health plans — will not be prepared to meet the specialized health care needs of some individuals with disabilities and chronic illnesses. We urge the Committee to consider this earlier proposal.

Another concern is that adult, non-cash assistance Medicaid beneficiaries who are receiving services not covered in the HSA mandated benefits package will lose these benefits. These include important services such as dental care and medical transportation for persons with no other means to access health services. Individuals with low incomes who have disabilities may need these services to achieve full functioning. (See the section on EPSDT for additional concerns about children's services under Medicaid). We are also concerned about those individuals who are currently working and continue to be eligible for Medicaid under Section 1619(b) of the Social Security Act.

CCD has major concerns about the co-payment requirements for individuals who are low income and who use a high volume of service. The cap on out-of-pocket expenses should be lower for low income individuals to prevent individuals from putting off care, which could lead to the development of more expensive complications.

Finally, CCD is concerned that persons eligible for long-term services should continue to receive optional Medicaid benefits such as rehabilitation, clinic services, personal care, home and community waiver services and case management. Given the major deficiencies in the proposed mental health benefit, in particular, the continuation of these services is particularly essential to individuals with mental illness. Therefore, CCD RECOMMENDS:

- Individuals currently eligible for Medicaid services should continue to receive the full range of Medicaid covered services.
- 2. Medicaid eligible and low-income individuals with disabilities or special health care needs must be able to access the full range of medically necessary covered health services to meet their needs, whether they are in a low cost or a high cost plan. If these services are not adequately provided in their plan, then these persons should be subsidized as needed to choose whatever plan will adequately meet their health care needs, including ongoing access to specialists, centers of excellence and other specialty care.
- The cost-sharing requirements for Medicaid beneficiaries and individuals with low incomes should be lowered to eliminate financial barriers to care.

# VII. Assuring Choice of Providers in all Managed Care Plans

As health care costs have continued to rise at double digit rates, insurers and employers have searched for ways to control costs. One response has been a growth in managed care plans of many different types. These include staff-model Health Maintenance Organizations (HMOs), Individual Practice Associations (IPAs), and Preferred Provider Organizations (PPOs). The number of people enrolled in managed health care plans has increased dramatically. Today, there are very few feefor-service plans that do not employ "managed care" techniques, such as utilization review and pre-admission certification for non-emergency hospitalizations.

Apart from a few well-established HMOs, such as Kaiser in California, the development of many managed care entities is a relatively recent phenomenon and there are serious concerns about some of the financial practices they employ to control utilization. CCD is concerned that while there are incentives in these plans to keep people healthy and decrease inappropriate utilization of expensive services, many plans offer financial incentives to decrease *appropriate* utilization. For example, some plans will withhold a percentage of a provider's income (15 - 20 percent) if they have exceeded a targeted number of referrals to specialists and hospitalizations. To address these concerns, *CCD RECOMMENDS*:

- 1. The Point of Service option for managed care plans must be maintained.
- 2. There must be strong provisions to assure that physician referrals to physician and non-physician specialists are financially neutral and based solely on the health needs of the patient. Just as physicians should not receive payment for referrals, so they should not receive payment for denying referrals. The legislation must expressly prohibit financial penalties for making referrals and bonus payments for not making referrals.
- 3. There must be a prohibition against balunce billing for medically necessary services obtained outside a network.

# A. Single Source Contracting

The Health Security Act currently preempts state laws that prohibit health plans from contracting with a "single source" to provide all of the services for a particular aspect of health care. For instance, under the HSA, health plans would be able to contract with one orthotic and prosthetic practitioner to provide all of the orthopedic braces and artificial limbs prescribed by physicians in the health plan. Similarly, one home medical equipment supplier could be chosen to service all of the home equipment needs of the plan's beneficiaries.

This approach is undesirable in a number of respects. First, qualified providers will be prevented from gaining access to and competing in the health care market. Monopolies of providers of particular types of services will be encouraged by this policy, thereby decreasing competition and eventually driving up prices. Some qualified providers could be forced out of business. The combined effect of allowing single source providers and decreases in the number of qualified providers in a given area will reduce the service options available to consumers. Consumers will be prevented from choosing a health care provider with whom they may have developed a long-standing relationship or one who is conveniently located.

The quality of care may also be compromised when managed care plans contract with a single provider for a specialized service. As an example, in the area of orthotics and prosthetics (O & P), many certified O & P practitioners specialize in different aspects of orthotic and prosthetic care. One may specialize in advanced upper limb protheses and another in orthopedic braces for the management of spinal conditions such as scoliosis. Other providers may specialize in advanced fitting techniques and material applications. In an area like O & P, where "one size does not fit all", allowing a plan to contract with a single provider severely restricts access to providers with expertise in a given area, and has to potential to seriously undermine the quality of care that a persons receives. Consumers must be given a real choice of providers for all services covered under a health plan. Therefore, CCD

#### **RECOMMENDS:**

- The legislation must include incentives for health plans to contract with as many providers as necessary to meet the health care needs of their beneficiaries, particularly persons with disabilities and chronic, disabling illnesses.
- No health plan should be allowed to engage in practices that have the effect of discriminating against any type or category of provider, or within a category of providers, as long as the provider is authorized under state law or regulations to provide health and mental health services. This will allow the consumer to have a real choice when selecting a health professional for a particular condition. This freedom of choice is particularly important for persons seeking mental health services, where interpersonal variables are important factors in treatment success.

## B. Gatekeepers

While the Health Security Act enables choice of providers outside of a managed care network, it does so at a substantial cost to the enrollee of at least 20 percent of the cost of the service, and there are no provisions to address the problem of balance billing for "out-of-network" services. In addition, in managed care systems, neither the person with a chronic condition or disability, such as severe spinal or head injury, stroke or cancer, nor the generalist gatekeeper are necessarily aware of the services available and needed. To remedy these problems, it is necessary to give individuals who need ongoing specialized services for their particular condition, a right to choose his or her gatekeeper physician, including an appropriate specialist for the condition involved. Each health plan would be obligated to create panels including specialists dealing with the major disabilities.

The National Health Board would define the conditions requiring specialized, ongoing care and would issue guidelines to assist plans in determining appropriate specialties to be represented on such panels. For example, specialists in physical medicine and rehabilitation would be relevant for managing spinal cord injury or head injury or stroke; specialists in neurology would be relevant for managing stroke, epilepsy, multiple sclerosis, and Alzheimer's disease; specialists in oncology would be relevant to managing cancer.

This right to choose one's main and primary physician is very important and particularly important to a person with a serious health problem. This right is all the more significant in managed care where the main or primary physician has gatekeeper functions. A specialist often is the main or primary physician in terms of personal contact and management for people with disabilities, and would generally be the best informed and competent manager of resources and services for persons with chronic disease or disability. However, managed care systems often prohibit the use of specialists in such roles. To address this problem, *CCD recommends the following change to Section 1402*:

# Requirements Related to Enrollment and Coverage by Health Plans

"(h) Any health plan which utilizes a gatekeepe: or similar process to approve health care services prior to their provision, shall provide each enrollee who has a chronic condition or disability likely to require substantial health care services over a prolonged period of time, a choice of his or her gatekeeper physician from a panel of physicians which shall include specialists in the medical management of the condition. The National Health Board shall develop and publish a list of the chronic conditions and disabilities that are likely to require substantial specialized health

care services over a prolonged period of time. The National Health Board is authorized to develop guidelines to assist health plans in determining which physicians are specialists in the medical management of the conditions or disabilities defined by the Board under this section. A health plan shall annually establish panels of physicians who agree to serve as gatekeeper physicians, including specialists in the medical management of chronic conditions or disabilities such as specialists in physical medicine and rehabilitation, and neurology.

# Suggested Report Language:

Individuals with chronic conditions or disabilities of a certain type including spinal cord injury, head injury, or stroke will often need ongoing medical management of a specialist in medicine. This person will often be the primary physician of the patient in terms of the amount of contacts with the patient and the decision making about his or her condition. Individuals with such conditions and disabilities generally desire to have a physician who specializes in the condition they have manage their care in managed care systems. This amendment provides that such individuals have a right to annually select a gatekeeper physician from a panel that shall include specialists in the conditions defined by the NHB as being of such a nature to require specialists case management rather than generalist case management. Many organizations representing persons with disabilities have urged that persons with disabilities be empowered to select a specialist as their gatekeeper case manager. Conditions which lend themselves to better case management by specialists are usually severe disabilities, for example spinal cord injury, multiple sclerosis, head injury, or AIDS. These conditions often affect many body systems and require a comprehensive approach to medical management and rehabilitation services. Specialists in treating such conditions are trained to understand such complex conditions and to be knowledgeable about the resources available to manage such conditions effectively. Physical medicine and rehabilitation specialists are trained and experienced in handling the comprehensive rehabilitation needs and most general medical problems of persons with severe physical disability of the neuromuscular and musculoskeletal systems. Specialists in neurology are trained and experienced in the diagnosis and medical management of persons with neurological conditions such as epilepsy, stroke and Alzheimer's disease.

# C. Access to Academic Health Centers and Centers of Excellence

Academic health centers are entities operated by or affiliated with a school of medicine or osteopathy or a teaching hospital. It is through such centers that many specialized treatments are available, including treatments for rare diseases and disorders, and for unusually severe conditions. A major issue of concern to persons with disabilities and special health care needs is whether persons in managed care settings will be able to receive services at specialized treatment centers. The Health Security Act says that a state "may" require alliances to assure that at least one accountable health plan has a contract with a "center of excellence." This provision does not adequately address the concerns of persons with special health needs. Additionally, we are concerned that persons with disabilities will be financially penalized for receiving medically necessary, specialist services outside the network if these services are not provided in the network. Given that a large percentage of the population is currently enrolled in managed care plans, and this percentage is expected to increase, it is essential that final legislation includes provisions to assure access for all Americans to academic health centers and centers of excellence. Therefore, CCD RECOMMENDS:

 Regional and corporate alliances must ensure that all health plans have sufficient contracts with eligible academic health centers and centers of excellence so their enrollees can receive specialized treatment services. There should be effective quality assurance mechanisms in managed care plans
to ensure that people with disabilities and chronic conditions who need
ongoing specialized services have appropriate access to these services, and
should not be financially penalized when their medical condition requires
specialty services.

# VIII. Consumer Involvement and Protections

To ensure that the health care needs of persons with disabilities are met, CCD RECOMMENDS:

- An advisory committee under the auspices of the National Health Board should be established to address the needs of persons with disabilities and chronic illnesses.
- There must be a formal process for the incorporation of consumer input in the development of "report cards" for health plans. Additionally, these report cards must assess not only the quality of care delivered to the "average" person, but must include assessments of the quality of care delivered to persons with disabilities and chronic health needs.

# IX. Education and Training of Health Providers

While the Health Security Act has provisions to increase the number of primary health care doctors and nurses, it has no comparable provisions to increase training for other key health and rehabilitation professionals including physical therapists, occupational therapists, speech-language pathologists, audiologists, respiratory therapists, rehabilitation psychologists, and nutritionists. These health professionals provide necessary services and supports to individuals with disabilities and their families. Many of these services enable individuals with disabilities to remain in their homes with their families, preventing the need for more costly institutionalization. Because there are documented shortages in many of these profession, *CCD RECOMMENDS*:

 The Health Security Act must include provisions to ensure a sufficient number of health and rehabilitation service providers.

Another major concern of CCD is the lack of education and training for both primary care providers and specialists in the delivery of health care to children and adults with disabilities. Like all Americans, individuals with disabilities need access to a range of primary health care services, which do not have to be provided by specialists in their particular disability. For example, children with mental retardation will experience the same broad array of health problems that are experienced by all children, e.g. ear aches, sore throats, chicken pox and other childhood diseases. Treatment for many of these problems is appropriately provided by a family doctor, a pediatrician, a pediatric nurse practitioner, or a physician assistant. All of these primary care providers, and specialists as well, need to be educated regarding the special needs of individuals with physical mental, and communicative disabilities. Therefore, CCD RECOMMENDS:

There must be provisions in the Health Security Act requiring that the training
of primary care providers include appropriate content dealing with the
delivery of primary health care for children and adults with physical, mental,
and communicative disabilities. This content should be available in both
basic education and continuing education programs. Programs providing this

content should be carried out in collaboration with physical medicine and rehabilitation programs or other specialty programs serving the needs of persons with physical, mental and communicative disabilities.

Finally, in determining the appropriate ratio of primary care providers to specialists, it is essential to consider secular trends in the incidence and prevalence of specific disabilities and illnesses. For example, in the past decade there has been a dramatic increase in the survival of persons with severe traumatic brain injuries and a concomitant increase in the need for neurologists, neuropsychologists, and rehabilitation psychologists to treat these individuals. Therefore, *CCD RECOMMENDS*:

 The National Council on Graduate Medical Education should be required to take account of the incidence and prevalence of disabling conditions, as well as changes in the needs of persons with specific disabilities, in determining the appropriate specialty mix needed.

# Closing

In closing, we would like to state that CCD is committed to working with both the Administration and Congress to assure adoption of our recommendations to improve the Health Security Act and to enact comprehensive health care reform in 1994. With the exception of President Clinton's plan and the Single Payer Plan introduced by Senator Wellstone and Rep. McDermott, all of the other bills currently being considered in the 103rd Congress fail to address the needs of persons with disabilities in fundamental ways. We strongly urge the Committee to reject those proposals that do not guarantee universal coverage for comprehensive benefits, protection from catastrophic costs, and cost containment measures that will slow the growth in health care costs so that comprehensive benefits remain affordable.

As you proceed with your work on health reform legislation, we would like you to remember one point: "In the long-term, the success of the health care system must be judged less on its success in serving the majority of the population, most of whom have few or simple medical care needs, and more on how effectively it addresses the needs of those with serious and persistent disabling illness, who depend on the health system for their functioning, perhaps even for their lives. To the extent that the reforms address their needs successfully, they are likely to serve us all well."

 Mechanic, David. Mental health services in the context of health insurance reform. The Milbank Quarterly, Vol. 71(3), 1993.

#### STATEMENT ON HEALTH CARE REFORM

On behalf of the millions of persons with disabilities, chronic illnesses and conditions -- those who are most vulnerable under the current health care system -- the undersigned organizations of the Consortium for Citizens with Disabilities (CCD) strongly endorses the need for far-reaching and comprehensive reform of the American health care system. The Consortium is a Washington-based coalition of over 100 national organizations concerned with disability policy, which advocates with and on behalf of people with disabilities. CCD member groups represent people with physical, mental, cognitive, and sensory disabilities and people with chronic, disabling illnesses.

For the past decade we have not had presidential leadership on this crucial issue. Based on the recognition that health care is a fundamental right of all Americans and a major economic issue for our nation, we strongly commend President Clinton for introducing the Health Security Act and committing his Administration to ensuring comprehensive, affordable health coverage for every American and for introducing a program that begins to expand long-term services for individuals with severe disabilities.

The U.S. health insurance system as it operates today fails persons with disabilities and chronic conditions in fundamental ways:

- It excludes persons with disabilities and chronic conditions as "medically uninsurable" or offers them insurance with pre-existing condition exclusions.
- It charges prohibitive rates to persons with ongoing health needs, making insurance unaffordable for many.
- It does not pay for many necessary health-related services, including long-term services and supports for persons with disabilities and chronic conditions.
- It places annual and life-time limits on health care services.

President Clinton's Health Security Act addresses all of these problems. It provides universal coverage for a comprehensive range of benefits and guarantees that no American will ever be without insurance, regardless of their employment status, income or health. Additionally, it establishes a new home and community-based long-term services program for persons of all ages with severe disabilities.

The Health Security Act also needs improvement in several key areas:

- Several provisions in the long-term services proposal need to be improved.

  The eligibility criteria under the proposed new home and community-based services program must ensure that all relevant factors are taken into account in determining the need for long-term services by persons with physical and mental impairments, and there must be assurances that a coordinated, comprehensive range of home and community-based services will be made available, both through this new HCB program and through the federal-state Medicaid program. There also needs to be a cap on out-of-pocket costs for long-term services.
- o Mental health services, home health care, rehabilitation therapies and durable medical equipment should be available without arbitrary limits. Currently the Clinton plan includes stringent limits on mental health services, forcing individuals who require ongoing health related services either into inappropriate (and often more costly) institutional settings, or into the inadequate and underfunded public system. Coverage for outpatient rehabilitation contains provisions that may limit access for persons with congenital, developmental, or other disabilities.
- Persons currently receiving services through Medicaid should not lose them.
   Medicaid services, such as the Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT) program for children, should continue to be available to eligible children.
- o Protections against undertreatment. The legislation should include effective quality assurance mechanisms for managed care plans to ensure that people with disabilities and chronic conditions who need ongoing specialized services have appropriate access to these services. Physician referrals to specialists should be financially neutral and based solely on the health needs of the individual. Additionally, access to specialists should not be based on one's ability to pay higher premiums, deductibles and copayments, or one's ability to purchase supplemental insurance.

There are many other important issues to be addressed, and numerous technical details that must be worked out before the bill is enacted. The task is a daunting one, made more difficult by the opposition of the many special interests who profit from the current system and who will fight to maintain the status quo. However, comprehensive health care reform must go forward. Every American must have the security of affordable, comprehensive health care coverage that is not dependent on their age, their income, their employment, or their health status. This is what the President promises and this is what we will fight for.

CCD is committed to working with both the Administration and Congress to assure adoption of our recommendations to improve the Health Security Act and to enact comprehensive health care reform in 1994. We will also vigorcusly oppose those who seek to maintain the current system and proposals that do not guarantee universal coverage for comprehensive benefits. All Americans need the security promised by the President's plan. Our nation cannot wait any longer for comprehensive reform.

# STATEMENT OF THE MASSACHUSETTS ASSISTIVE TECHNOLOGY PARTNERSHIP CENTER

People with disabilities have been referred to as the litmus test for an effective health care plan. While they share in the same crisis of coverage as do other Americans, they also experience additional barriers in the health care system. People with disabilities require services which sooner or later in their lives all Americans may need—services such as assistive technology and personal assistance services. These services have not been consistently available under public or private insurance, creating great hardships and in many instances compounded health problems for millions of Americans.

The proposed Health Security Act has the potential to meet the needs of people with disabilities effectively. Through its goals of providing universal coverage and eliminating exclusions based on pre-existing conditions, it goes far toward meeting the needs of people with disabilities and those who are aging. In its current version it falls short on its promise to individuals with disabilities due to inconsistencies in coverage of essential services. There have been many efforts and much progress in the past several months to address these issues in the bill through proposed amendments.

In this testimony we offer comment on the need for addressing assistive technology coverage in the context of health care reform, and on progress in addressing issues which remain in the bill.

## The need for coverage of disability-related services in health care reform

Two reports to the President and to Congress which were completed by the National Council on Disability (NCD) one year ago describe the need for improved health care coverage for people with disabilities. A Disability Perspective on Access to Health Insurance and Health-Related Services, by NCD, reports many findings that are relevant to any proposed health care reform efforts. We mention just a few of these here:

"The public health insurance system in the United States fosters dependence rather than independence and isolation rather than integration....Limitations in the range of services covered under public programs may require that an individual be institutionalized to receive needed services."

"The emphasis on acute and episodic care rather than on prevention and wellness runs counter to the needs and objectives of many persons with disabilities."

"The range of services covered by insurance is typically limited and often restricts or excludes coverage of many services that are important for persons with disabilities to achieve independence."

Financing Assistive Technology Devices and Services for Individuals with Disabilities, also by the National Council on Disability, notes that:

"Typically, reimbursement for assistive technology devices and services in the health care system conforms to the requirements of the funding source, not to the functional needs of individuals with disabilities."

"Once individuals with disabilities obtain needed technology, little attention and funding support are given to training and ongoing assistance and maintenance needed to maximize benefits to the user."

These comments provide just a brief glimpse of the implications of inconsistent coverage of services needed by individuals with disabilities in health care programs. Key among essential services discussed in these reports are personal assistance services and assistive technology.

# The role of assistive technology as part of disability-related services

In 1988 Congress passed the Technology Related Assistance for Individuals with Disabilities Act (the "Tech Act"), P.L. 100 407, in recognition that there exists a growing number of assistive devices and services which can facilitate the independence of individuals with disabilities in education, employment, and daily life; and directing state Tech Act projects to identify the needs of individuals with disabilities in their states and to acdress barriers in systems which provide coverage of assistive technology. Just three weeks ago when Congress reauthorized the Tech Act, it strengthened the systems change mandate of state Tech Act projects.

Of major concern to participants in the consumer-responsive state Tech Act projects is the coverage of assistive devices and services under a reformed health care system. Assistive technology devices include items such as a wheelchair for an individual with mobility impairment; an augmentative communication device for an individual with a speech related disability; an assistive listening system for an individual who is hard of hearing; a white cane for an individual who is blind; and an electronic memory aid such as a timer for an individual with a cognitive disability such as a head injury. These often simple devices can make an enormous difference in the functioning of individuals with disabilities and those who are aging. Assistive technology services, which are crucial to appropriate selection and utilization of assistive devices, include services such as assessment of an individual's needs by a professional such as physical therapist, audiologist, or other qualified health professional; and prescription, fitting, training, or maintenance so that the device will be utilized as effectively as possible.

Assistive devices are a part of the natural evolution of the concept of durable medical equipment, prosthetics, and orthotics, in the context of the evolving field of rehabilitation therapy services. Since the term durable medical equipment was first defined over 25 years ago in the Social Security Act, this antiquated definition has evolved through different interpretations over the years as people with disabilities have left the confines of homes or institutions to become more mobile and integrated into society; as society has placed greater value on "aging in place" rather than entering institutions as we grow older; and as a greater variety of technological solutions have become available which can replace or augment functional capabilities.

Assistive technology devices and services perform a vital role in preventive health care for individuals with disabilities. Assistive technology is often the first line of defense in prevention of secondary disabilities. A properly fitted wheelchair with customized seating can save the health care system dollars which would otherwise be spent further down the road on treatment for pressure sores from poorly fitted seating, to say nothing of the savings to the individual in pain and suffering. Preventive prescription of assistive devices can greatly slow the development of conditions such as post-polio syndrome, or overuse syndrome which is becoming increasingly recognized as a secondary disability which can develop over time in conditions previously considered stable, such as spinal cord injury, cerebral palsy or spina bifida. A hearing aid plays a vital role in prevention through reducing isolation of an aging individual with hearing loss, by enabling access to medical and other services necessary to sustain life. The traditional concept of "prevention" in health care services does not adequately encompass either the needs or the solutions available to people with disabilities as a part of health care coverage. The concept of prevention in health care reform needs to expand to include services such as assistive technology which form part of the treatment options utilized by people with disabilities.

#### Overview of concerns relating to coverage of assistive technology

There are several overall themes underlying these comments. These include: that people with disabilities need access to assistive technology from within all parts of the plan; that people need access to assistive devices and services, regardless of their type of disability; that assistive technology services must be adequately covered to ensure full utilization of devices that are provided; that assistive technology is not a substitute for personal assistive services, but is mutually complementary and necessary; and that individuals with disabilities need to play as direct a role as possible in all stages of acquiring assistive technology, and likewise to have representation on advisory boards which oversee development and implementation of policies related to provision of assistive technology devices and services.

# Comments on specific issues relating to coverage of assistive technology devices and assistive technology services in health care reform

In this section we address specific areas where coverage of assistive technology or related services is unclear or incomplete.

1. A clarifying amendment for \$1124. Durable Medical Equipment, Prosthetics, and Orthotics, in the proposed HSA, would ensure the coverage of assistive technology devices that is apparently intended in the bill's language for prosthetic devices.

We commend the Administration for including a definition in the proposed Health Security Act of "prosthetic devices" that reflects technological advances which have been incorporated into contemporary practice by health care professionals. Technological advances are enabling health care professionals to prescribe devices, such as argmentative communication devices, that replace all or part of the function of an internal body organ or external body member, without surgically inserting or physically attaching the device to the body. Applying this contemporary "functional" definition of prosthetic devices enables coverage of external devices, subject to the same restrictions in the general policy that all devices provided under the comprehensive benefits package must be prescribed by a qualified health care professional within the scope of the professional's practice, and must be medically necessary or appropriate under the comprehensive benefit package. Inserting the phrase "including external devices" to the definition of prosthetic devices would acknowledge that not all prosthetic devices are surgically inserted or physically attached, and would accurately capture current medical practice.

2. An amendment to \$1123. Outpatient Rehabilitation Services, would ensure access to essential outpatient rehabilitation services without the discriminatory effects of the current language which limits coverage to conditions due only to "illness or injury."

Changing coverage under this section from "conditions due to illness or injury," to "conditions due to illness, injury, disorder or other health condition," would eliminate the discriminatory effects of the current language with its de facto pre-existing condition exclusions for congenital conditions, and replace it with a standard that would appropriately capture the range of human conditions requiring outpatient rehabilitation services. Adding audiclogy to the list of covered services would appropriately address the rehabilitation services needs of individuals who are deaf or hard or hearing. Removing the restrictive language regarding speech-language pathology would provide a more appropriate range of service. Reinforcing the role of rehabilitation services in maintaining functioning and in preventing deterioration in functioning would more appropriately cover the range of rehabilitation services required by people with disabilities to retain their functional abilities.

3. The discriminatory effects of the current language of \$1141. Exclusions, are of great concern. These could be addressed through an amendment modifying the effect of the hearing aid exclusion.

While the language in \$1124 holds a promise of an appropriate range of cross-disability coverage, the outright exclusion of hearing aids under \$1141 belies this promise by eliminating one of the most cost-effective assistive technologies for a disability population. There are many ways to provide coverage of hearing aids without incurring a demographic debacle; one approach would be to provide coverage of hearing aids only where prescribed by a licensed, dispensing audiologist. This would have the effect of restricting coverage in those instances where there has not been a proper fitting, or in instances where an individual cannot realistically benefit from the use of a hearing aid as evaluated by a qualified practitioner. We encourage the exploration of data which state Tech Act projects are currently collecting regarding demographics of hearing aid usage and possible solutions for providing coverage with appropriate restrictions.

A related concern under this section is that of a possible umbrella effect of exclusion of assistive technologies which might "look, taste, or smell like" items specified under §1141. Examples include personal assistive listening devices which perform a similar function to that of hearing aids, and low-vision aids such as bioptics or magnifiers which perform a similar function to corrective lenses which, according to §1141 are excluded for individuals over the age of eighteen. We recommend that a determination on this issue be made, and that if there is a risk of a carry-over exclusionary effect, that this issue is addressed, so that whatever exclusions may remain regarding coverage of hearing aids and corrective lenses do not have the unintended effect of restricting coverage of assistive technology devices which otherwise would fall under the scope of §1124.

4. The status of coverage of the full range of assistive 'echnology services is unclear. This could be reinforced in statutory or report language for \$1124.

Appropriate utilization of services such as assessment and training are cost-effective in that they increase the likelihood of appropriate selection and full utilization of purchased equipment. The

current amendment specifies certain assistive technology services in the proposed statutory language -- fitting, training, repair and maintenance -- but this can be reinforced at the level of report language to clarify that the full range of necessary services are included. Demonstration of devices, a trial period, and assessment of the individual's needs are all services which can be essential in selection of appropriate devices for individuals, in addition to the customization, training, and maintenance which may be required.

5. The definition of durable medical equipment (DME) is out of date. This could be addressed through separate efforts which would also affect Medicate and Medicaid services.

An updated definition of durable medical equipment is long overdue. While it is not practical to modify the definition of DME within the structure of this section of the proposed Health Security Act, recent discussions have re-demonstrated the need for updating this language. Most problematic are two elements in the criteria for DME: the criteria that the "primary use" of a covered item must be medical, and the criteria of "medical necessity." If the Administration pursues a redefinition of durable medical equipment in the future, we recommend that coverage of devices needed by individuals with disabilities be considered in examining the adequacy of any new definition.

The "primary use must be medical" criteria of DME hinders coverage of items such as air conditioners even when medically indispensable, since air conditioners are not designed primarily as medical devices, even in cases where individuals with severe asthma, emphysema, or other acute respiratory conditions would otherwise be hospitalized. The "primary use must be medical" criteria also creates greater cost to the system, for example for items such as augmentative communication systems which increasingly can be purchased more economically as laptop based computers with specialized software than when purchased as stand-alone devices; or items such as environmental control systems which in some cases can be satisfactorily assembled from hardware store parts (X-10 remote activators, adapted switches, etc.) at a tenth the cost of units that have been pre-designed to fill a specifically "medical" function.

The criteria of medical necessity creates many problems in the coverage of essential assistive technology devices. Items such as raised toilet seats or grab bars are frequently denied by Medicare or Medicaid as "not medically necessary" even though they may provide the first line of defense in prevention of secondary disability. An example would be that of an individual with an unsteady gait, muscle weakness, and osteoporosis, where a raised toilet seat or grab bars might be the best defense against the likelihood of a broken hip with subsequent hospitalization and the possibility of permanent loss of ambulation. While the criteria of "medically necessary or appropriate" in this bill represents an improvement over a strict criteria of medical necessity, the linkage of medical appropriateness to prevention of secondary disability needs reinforcement in this bill. For efforts to redefine DME, a more appropriate criteria to capture coverage of essential devices for individuals with disabilities would be an alternate criteria of "functional necessity."

The DME criteria that an item be "appropriate for use in the home" is also of dubious relevance; gone are the days when people with disabilities are expected to while away their hours between the same four walls — although this is unfortunately the situation which prevails in many instances when people do not have access to assistive technology and personal assistance services.

6. Long-term care programs—home and community based care—while authorized to provide coverage of assistive technology devices and services for individuals with disabilities, by no means guarantees that coverage.

Many people with disabilities cannot survive outside of restrictive institutional settings unless they have access to personal assistance services. Personal assistance services for many create a foundation which enables them to realize the benefits of other services such as assistive technology. Personal assistance services and assistive technology are both essential services in a program of national health care, and they both meet different needs. Neither service can replace the other, and in many cases they need to be used together to ensure the most effective and appropriate service.

We applaud the Administration's recognition of assistive technology devices and services as authorized expenditures under the home and community-based services programs of the Health Security Act, to address those situations in which such devices are not otherwise covered under the comprehensive benefits package. At the same time, we note that many individuals requiring assistive technology devices, because of a functional limitation such as a speech, hearing or vision disability, would not qualify for services under the long term care section because the eligibility test for "disability" in this section is essentially whether or not one requires a significant level of handson or cueing personal assistance services; and in addition, we note that with the exception of personal assistance services under long term care are optional for states to provide. Therefore we caution that the mention of assistive technology under home and community-based care cannot substitute for coverage under the comprehensive benefits plan.

#### Conclusion

Disability is not an isolated condition but rather a natural part of the human condition. We can all become disabled; we hope, when that happens, that the essential devices and services which help us to maintain our health and functioning will be items that our health care plans are familiar with and prepared to offer when needed.

The proposed Health Security Act provides an excellent foundation for considering the needs of disabled and aging Americans among those whom this plan is intended to cover. We hope that these comments are informative as to areas of concern in making this or any health care legislation inclusive of the needs of people with disabilities, and we welcome and will assist with efforts to ensure that health care reform addresses the needs of all Americans.

#### STATEMENT OF THE AIDS ACTION COUNCIL

AIDS Action Council is pleased to submit testimony for the hearing record of the Senate Labor & Human Resources Committee on the impact of President Clinton's Health Security Act on people living with HIV/AIDS. AIDS Action Council serves as the Washington representative for over 1,000 community-based organizations providing services to people living with HIV/AIDS. Since 1983, AIDS Action Council has been exclusively devoted to advocacy for effective national HIV/AIDS policy. In that role, we have seen first-hand the devastating failures of our current health care system, and believe that health care reform represents one of the most important pieces of federal legislation ever for people living with HIV/AIDS across this nation.

#### INTRODUCTION

Over a million Americans are living with HIV infection today. These individuals are living and dying — in every region of this country, in rural, urban and suburban communities. The faces of people living with HIV/AIDS are the faces of America; tragically, there is no racial, ethnic, age or gender group in this nation that has not been affected by this epidemic. Since 1981, over 350,000 men, women and children have been diagnosed with AIDS in America. More than 200,000 of the total have died. We will never know how many of those individuals died prematurely or experienced unnecessary suffering because of the failure of our health care system to provide appropriate medical management of HIV disease.

People living with HIV/AIDS are poorly served by the current system. Forty percent of people with AIDS are Medicaid recipients and at least 30 percent are uninsured. Even for those who are insured, discrimination by insurers, caps on overall care for AIDS treatment, pre-existing condition exclusions and a range of other common insurance practices make obtaining health care a frustrating, financially debilitating and sometimes, life-threatening experience for Americans living with HIV/AIDS.

It is a truism in the HIV community—people living with HIV/AIDS, their families and triends, service providers and other advocates—that the American health care system is in crisis. It is our firm belief that any national health care reform plan enacted by the Congress can be judged by its responsiveness to the health care needs of Americans living with HIV/AIDS, because HIV disease presents a broad spectrum of health care needs—from the provision of antiviral and prophylactic prescription drugs to keep relatively healthy people living with HIV healthy, to acute care for opportunistic infections, to home-based, long-term, and ultimately hospice care for those in the end stages of the disease.

Since the beginning of the epidemic, the HIV community has pushed for fundamental reform. We salute President Clinton for the leadership and commitment which is reflected in the Health Security Act.

I want to talk to you today about the fundamental elements of the Administration's Health Security Act which must be preserved by the Congress if national health care reform legislation is to be meaningful to Americans living with HIV/AiDS. In doing so, I will also be taking this opportunity to mention some things in the Health Security Act which we believe need to be

strengthened. I want to say at the outset, however, that we have reviewed many of the plans pending before Congress, and that although we believe there are areas of the Clinton plan that need to be strengthened, we are convinced that none of the other plans (with the notable exception of the McDermott single payer plan) offer the American people meaningful reform.

# UNIVERSAL COVERAGE BY A DATE CERTAIN

It is imperative that the principle of universal coverage, identified as one of President Clinton's "bottom lines", be a bedrock for health care reform. Universal coverage must not be confused with merely a universal opportunity to purchase coverage for those healthy and wealthy enough to do so. We have that now, and it is why there is a health care crisis in this country. Universal coverage must apply to everyone at the same time — legislative phase-in schemes which make universality contingent on future financial and political exigencies are schemes which do not in fact guarantee universal coverage. The Clinton plan's 1998 target for universal coverage must be non-negotiable. Even that will come too late for hundreds of thousands of Americans living with AIDS who will never live to benefit from it.

Universal coverage requires true community rating, across the widest possible pool of consumers. Universal coverage means coverage that is not solely dependent on individuals to finance the system alone. Employers must be required to make a financial contribution if universality is to be real. And government must provide financial subsidies for the unemployed and for low-income individuals and families, regardless of employment status.

When we talk about universal coverage, we mean that all Americans must be allowed to enroll in whatever plan meets their needs, and not be prevented from choosing a plan because of their health status or because of pre-existing condition exclusions.

Universal coverage means complete portability of coverage. The employment status of people living with HIV/AIDS changes as their illness changes and progresses. People with HIV/AIDS and other Americans with chronic illnesses and disabilities should have the opportunity to work without jeopardizing the ongoing health care services so vital to their functioning and well-being. It is now commonplace for people living with HIV/AIDS and other chronic illnesses to find themselves forced to choose between working and getting health care; because their employers and/or insurers will not provide health care coverage, they are forced to impoverish themselves to get into the Medicaid program.

President Clinton's Health Security Act contains these essential components of universal coverage. We have several concerns, however. For example, while we commend the Administration for including an employer mandate in its proposal, we fear that the current provisions regarding corporate opt-out for employers of 5000 or more could threaten the financial stability of the reformed system, especially if the threshold for opting out is lowered. The corporate opt-out will create corporate pools of healthy, young, generally higher-income individuals, and turn the state alliance system into a high-risk pool of the poorest and sickest, thus shifting costs back to the states and public/non-profit health providers. Even with the required corporate contribution to the regional alliance system, we believe the corporate opt-out provision may undermine reform.

We are also concerned that neither undocumented persons nor incarcerated individuals are included in the definition of "universal coverage" in the Clinton plan or any of the other proposals under consideration.

These concerns underscore the vital importance of preserving and expanding current federal and state programs which provide basic health care services to populations with significant rates of HIV infection. Until we are sure of the effects of health care reform, we must keep the critical safety net programs in place. I will discuss those programs more fully later in my testimony, but want to turn now to the issue of the comprehensive benefits package.

#### GUARANTEED COMPREHENSIVE BENEFITS PACKAGE

A guaranteed comprehensive benefit package must be included in the health care reform measure passed by Congress. Guaranteed coverage in a plan that does not provide a minimum comprehensive set of benefits is meaningless. The nature of HIV disease and other chronic and disabling conditions requires access to a full range of health care services to ensure quality care. The Health Security Act guarantees a comprehensive benefit package which contains elements critical to people living with HIV/AIDS like prescription drug coverage including off-label use, mental health and substance abuse services, hospice care and home and community-based long term care. All of these health care services are essential for people with HIV/AIDS. A benefit package without prescription drug coverage, for example, would deprive AIDS patients of a benefit vital to the quality and duration of their lives.

AIDS Action commends the Administration for guaranteeing a comprehensive benefit package that includes these key elements. However, we feel strongly that improvements must be made in this benefit package if it is to truly provide the basic health care services people with HIV/AIDS need.

#### Recommended Improvements in the Health Security Act:

#### Prescription Drug Coverage

- Create a drug formulary at the national level to ensure that coverage would be consistent regardless of plan enrollment or geography.
- Include coverage for investigational treatments for life-threatening conditions outside of clinical trials.

#### Mental Health and Substance Abuse Services

- Separate coverage for mental health services and substance abuse treatment so that
  individuals don't have to choose to receive coverage for one or the other of these
  conditions.
- Eliminate the swapping arrangement in the mental health and substance abuse benefit between inpatient care, intensive outpatient services and outpatient services which undermines access to a continuum of care.
- Make copayments for mental health services and substance abuse treatment equal to copays for other health services and count all payments for these services toward the outof-pocket maximum.

#### Home and Community-based Long Term Care Services

Modify eligibility criteria to enable people with AIDS and other terminal illnesses who
are in the last 24 months of life to access this humane, cost-effective alternative to acute
care hospital placement.

#### Preventive Services

- Broaden fertility-related STD testing to cover all STD testing as a preventive benefit apart from the deductible with no copayment for individuals aged 13 and above.
- Increase the frequency of PAP smears covered under the preventive benefit.

#### AFFORDABILITY AND CHOICE

Access to quality health care must be available to poor as well as to wealthy Americans and to the chronically ill and disabled as well as to those of us in good health. Therefore, it is critical that components of the Administration's proposal regarding premium caps and limitations on copayments and out-of-pocket maximums not be abandoned by the Congress, but rather enhanced and improved.

There has been a great deal of talk about "choice" in the health care reform debate so far, but too little discussion about the relationship between choice, affordability and quality care. All health care providers do not have expertise in treating HIV disease. Moreover, there is ample documentation to show that far too many health care providers are unwilling to treat patients with HIV/AIDS. People with HIV must be able to choose plans that have compassionate providers with HIV expertise on staff. Expensive premiums present a barrier to low-income individuals with chronic illnesses like HIV from choosing the plan most likely to meet their medical needs. While we commend the President's plan for integrating Medicaid recipients into the mainstream

health care system and guaranteeing the same benefits package for all Americans, we are concerned that the subsidy scheme in the Health Security Act which caps subsidies at the cost of the average cost plan reduces the choices of low-income sick and disabled people to choose a plan with the staff and resources they need.

# Recommended improvements in the Health Security Act:

- Allow full subsidies for low-income disabled individuals, including Medicaid recipients, to subsidize premiums and out-of-pocket expenses for those who must choose higher cost plans to access providers competent to address their special needs.
- Allow full subsidies for individuals and families up to 150 percent of poverty; implement
  a sliding fee scale for people from 150 to 200 percent of poverty.
- Cap premium expenditures at 3.9 percent of income for any plan selected by people earning \$40,000 or less (not just up to the average cost plan).
- Pro-rate out-of-pocket payments on a monthly basis so that people with chronic illnesses like HIV/AIDS will not be faced with having to pay the entire out-of-pocket maximum in a month or two.

#### PRESERVATION OF VITAL PUBLIC HEALTH CATEGORICAL PROGRAMS

The Administration's bold plan to integrate all Americans, including poor individuals and other traditionally underserved populations into the mainstream health care delivery system is a laudable, but untried goal. From the perspective of the HIV community, it is imperative that federal safety net programs, including the Ryan White Care Act, the substance abuse block grant, federal tuberculosis initiatives and federally-funded HIV prevention programs remain intact during the transition to national reform and until it can be clearly demonstrated that the health alliances can provide the services currently provided by these programs. Many of these programs provide services which will not be available through the health care system. Case management and adult dental services are just two of the services currently provided under Ryan White which will not be available through health plans. The substance abuse block grant is the primary source of funding for long-term community based residential care for drug dependent persons, including women with dependent children. The substance abuse benefit simply will not provide services of that duration or intensity of care and it would be short-sighted to finance the substance abuse/mental health benefit with federal substance abuse block grant funds. AIDS Action will work to preserve and enhance funding for public health programs critical to the well-being of persons living with HIV/AMDS.

#### ANTI-DISCRIMINATION PROTECTIONS

Perhaps no group of Americans has experienced the tragic effects of discrimination in the health care system as acutely as people living with HIV and AIDS. We believe that any efforts to reform the health care system in this country will fail if guarantees of anti-discrimination are not explicitly set out in the law and enforced in practice. The incentives to deny health care coverage to Americans on the basis of their health condition, anticipated need for services, socioeconomic status, race, or gender, particularly in managed care systems, will continue to exist, whether overtly or not, even if the essential elements we have spoken about today are included in health care reform.

Insurers and health care providers have significant financial incentives to deny health care coverage to sick people. Structural changes in the health care delivery system as proposed in the President's plan, including risk adjustment by disease and by socioeconomic status for payments to providers, are critical to substantially reducing, if not eliminating, these incentives. Nevertheless, given the widespread discrimination faced by individuals living with HIV/AIDS and other illnesses, we are convinced that health care reform efforts will fail if guarantees of due process, confidentiality of medical records, and anti-discrimination are not explicitly set out in the law and enforced in practice.

We commend President Clinton for including provisions in the Health Security Act that will ensure that Americans are given meaningful due process rights to appeal wrongful denials of care. We commend the President for including provisions to prohibit discrimination based on

health care condition, socio-economic status, race or gender; discrimination that for lar too long has prevented people with HIV/AIDS from getting appropriate and affordable health care. However, we do have concerns regarding issues such as the potential for redlining, the lack of clarity regarding burdens of proof in discrimination cases, and the lack of specificity regarding the National Health Board's review of state plans for compliance with the anti-discrimination and consumer protection requirements in the Act.

We further commend the President for recognizing the importance of assuring all Americans that their medical records will be kept confidential, and for providing that data collection for utilization reviews, quality assurance and report card programs, and other purposes should only utilize blinded, aggregate data. These confidentiality protections are essential to ensuring that all Americans are protected from discrimination. Again, we do have some concerns about the lack of specificity regarding the National Health Board's review of state plans for compliance with these protections. We fear that misuse of data could result from the potential failure of the National Health Board to promulgate adequate, comprehensive standards for health data systems prior to the approval of any state plan. Despite these concerns, we believe that the President's plan is an enormous step in the right direction and we are committed to working with the Administration, Congress, and other consumer groups to address these concerns.

#### CONCLUSION

Health care reform is one of the most important pieces of federal legislation ever to come before the Congress. The claims of those who benefit from the status quo that the American health care system is not broken ring untrue to the millions of American families affected by HIV/AIDS. The system is broken, and we must fix it. The Health Security Act of 1993 would make health care a right, rather than a privilege reserved for the healthy and affluent. The promise of the President's proposal, to provide all Americans with comprehensive, affordable and appropriate health care by 1998, must be realized. We urge this Committee to support the Clinton plan's guarantees of universal coverage, a guaranteed comprehensive benefits package, affordability, and protection from discrimination, for the sake of all Americans.

#### STATEMENT OF EDITH G. SMITH

#### Mr. Chairman and Members of the Committee:

My name is Edith Smith from Springfield, Virginia I consider myself to be a traditional military wife and volunteer citizen advocate for disabled military retirees, dependents, survivors, and certain former spouses. I represent no organization. I appreciate the opportunity to express my views before this Committee concerning the unequal healthcare coverage provided by the Department of Defense to disabled military beneficiaries under age 65 solely because they suffer the mistortune of serious/calastrophic disability or end stage renal disease (ESRD).

The Uniformed Services Health Benefit Program provided to military employees and their families by the Department of Defense consists of two parts: 1.) Health care at Military Treatment Facilities which (except for the active duty member) is subject to the availability of space and personnel for all eligible beneficiaries. 2.) In 1956, Congress established The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) as the guaranteed part of the healthcare delivery program provided to all military retirees as an entitlement of their retirement. Congress mandated that the coverage provided by CHAMPUS would equate to the coverage provided by the Federal Employee Health Benefits Plan, Hi Option BC/BS. (In compliance with Federal Law regulating Insurance, FEHBP does not "dump" their disabled from coverage.)

The Department of Defence has testified before Congress that the barrier to providing equal CHAMPUS entitlement to disabled beneficiaries is the cost.

Medical care for disabled DOD beneficiaries is "cost shifted" to other agencies; resulting in "cost savings" for DOD and a significant loss of coverage for these individuals with severe disabilities. From 1972 until 1991, eligibility for CHAMPUS entitlement was terminated when a beneficiary under 65 became entitled to Medicare Part A due to disability or ESRD. In 1991, Congress partially restored CHAMPUS as second payer to Medicare Part A for eligible beneficiaries under 65

I am concerned President Clinton's Healthcare Reform may unintentionally repeal this recent restoration of partial CHAMPUS coverage to these beneficiaries with disabilities and switch them back to the lesser coverage of Medicare. A basic principle of Healthcare Reform is to expand employer-provided coverage to all workers. How can we require small business employers to provide health insurance equally to all workers when, under the new proposal, a government agency is still allowed to "cherry pick" certain beneficiaries solely because they are disabled?

There are 6 million CHAMPUS beneficiaries. The Defense Eligibility Enrollment System reports that 16,440 individuals are listed as under 65 and eligible for Medicare Part A. The majority of CHAMPUS beneficiaries are dependents or non-service connected retirees who are not eligible to receive healthcare at a Veterans Affairs Medical Facility. The unjust loss of more generous CHAMPUS coverage is an insult to the already injured and often results in financial devastation to the beneficiary. DOD abandons a responsibility to provide equal access to all benefits of retirement for all retirees. Why is the Department of Defense allowed to "cost shift" this financial burden of the sickest retiree to Medicare and Medicaid? Why does DOD willingly shoulder premium subsidies of the Federal Employoos Health Benefits Program for their disabled civilian retirees and not be similarly responsible for their military retirees?

President Clinton, Members of Congress, and the majority of American citizens endorse universal health coverage; seeking an end to discrimination of individuals with pre-existing conditions and disabilities by insurance companies. I encourage this committee to support legislation which provides equal access to adequate healthcare coverage by all Americans. Begin this endeavor by legislating changes in the law that require all Federal Agencies, such as the Department of Defense, to provide equal opportunity for disabled beneficiaries for eligibility for otherwise earned retirement entitlements.

STATEMENT OF THE AMERICAN ORTHOTIC AND PROSTHETIC ASSOCIATION

# Introduction

Thank you for this opportunity to introduce the American Orthotic and Prosthetic Association (AOPA) and to discuss national health care reform and the needs of Americans with disabilities. AOPA commends the President and Congress for their diligence in the health care reform debate. AOPA is honored to be included in the debate on health care reform to achieve quality, accessible, and comprehensive coverage for all Americans.

The American Orthotic and Prosthetic Association is the national membership organization representing the approximately 1,200 facilities that provide orthotic and prosthetic (O&P) patient services to the physically challenged throughout the United States. Practitioners employed by AOPA members design and fit orthoses and prostheses (braces and artificial limbs) that enable physically

challenged individuals to overcome often serious and crippling injuries and return to productive lives. Most of our patients return to their homes, work, schools, or active retirement.

The expectation of health care reform gives America an opportunity to maximize the quality and productivity of its citizens' lives by strengthening the role of rehabilitative services in the delivery and financing of health care in this nation. In this cooperative spirit, the following points must be addressed regardless of the health care model ultimately passed by the Congress.

#### National Health Care Reform Recommendations

Coverage: Basic health care benefits legislation should incorporate universal access to care, comprehensive and quality health care services, and consistency in coverage/cost-effectiveness. Any legislation designed to reform the current health care system should recognize O&P as an essential ingredient of any basic health care benefits package. The patients' freedom of choice must be maintained during establishment of national health care or during any modification of the present system. Finally, any legislation designed to reform the current health care system should emphasize preventive care as a priority.

Medical Necessity Criteria: The application of medical necessity criteria must be fair and consistent and make extensive use of practitioner input. It is appropriate and necessary to include functionality as a valid medical necessity criterion. The continued exemption from completing certificates of medical necessity is appropriate for O&P. Long term, cost effective treatment of a patient should be the primary consideration for both clinicians and policy makers.

Reform Insurance Practices: Pre-existing conditions should not exclude anyone from obtaining comprehensive insurance. In addition, claim form uniformity would save significant time and cost, for both practitioners and insurers, thus reducing the cost of health care. Regarding malpractice insurance reform, AOPA would support limitations on jury awarás for pain and suffering, guaranteed coverage of all allied health practitioners with a system to accommodate high-risk specialists.

Language in the Health Security Act: AOPA is supportive of the language in President Clinton's plan which states, "leg, arm, back and neck braces, artificial legs, arms and eyes" including "replacements if required due to a change in physical condition" are included as standard benefits. The fact that training for the use of prostheses and orthoses is also included in the standard benefit package which is an extremely important aspect of O&P care only serves to emphasize the importance President Clinton is placing on rehabilitative care. In addition, the Health Security Act includes "accessories and surplies used directly with a prosthetic device to achieve the therapeutic benefits of the prosthesis or to assure the proper functioning of the device." AOPA strongly supports this language and President Clinton's deep commitment to rehabilitation and comprehensive health care.

#### Conclusion

No one can deny that rehabilitation improves people's lives and their productivity. Furthermore, rehabilitation services are cost effective. Studies show that for every dollar spent on rehabilitation, at least \$11 are saved. The earlier a decision to rehabilitate a patient is made, the more likely that patient will

return to work. Rehabilitation permits disabled patients to resume active daily lives, which include returning to home, school, and or work. Rehabilitation generates revenue by enabling people to return to their functional independence, stop claiming wage compensation, require less social services, and not only reduce the total American tax burden but, in most instances, return to the status of "tax-payer".

AOPA supports a team approach: the physician, prosthetist/orthotist and therapist, as well as the patient, making decisions together. Providing O&P rehabilitation instead of long term care is an investment and good public policy — for our tax dollars, for fulfilling the spirit of the Americans with Disabilities Act, and for preserving the dignity and self-worth of our physically challenged population. This continued call for awareness will enable the nation's lawmakers to make wise decisions regarding every American's access to O&P skills. Clearly, we must allocate adequate funds to services that rehabilitate people.

JOINT STATEMENT OF THE AMERICAN THERAPEUTIC AND RECREATION ASSOCIATION AND THE NATIONAL THERAPEUTIC RECREATION SOCIETY

# HEALTH CARE REFORM: THERAPEUTIC RECREATION'S POSITION

The American Therapeutic Recreation Association (ATRA) and the National Therapeutic Recreation Society (NTRS) support the commitment of President Clinton and the U.S. Congress to make health care a right for all Americans. We applaud the commitment to universal coverage, the principles of portability and affordability, the elimination of pre-existing condition exclusions, and the applicability of the federal civil rights statutes associated with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

In order for health care reform to be truly effective, we believe it is necessary to expand the view of health care from an over-emphasis on acute care to a system that fully embraces prevention, rehabilitation, and chronic care management, as well. We believe health care reform should be guided by the health promotion and disease prevention objectives contained in the <u>Healthy People 2000</u> report. Therefore, we take this opportunity to present ideas and concepts that will contribute to cost-effective and quality health care reform.

#### The Concept of Health:

It is time for the health care system to replace the dichotomous view of health (i.e., a person is either sick or healthy; health is not given consideration until the person is determined to be ill), and to recognize that a state of health is the relative capacity to participate fully in life. Therefore, we urge that health care reform initiatives reject the idea that health is simply the "absence of disease," and instead be guided by a more accurate concept of health as part of a wellness continuum. This broader concept of health would recognize the vast majority of persons who have relative degrees of being "at-risk" for, or are relatively resistant to, declines in health status, functional capacity, and quality of life. In particular, more than 43 million Americans with disabilities and the many millions of Americans who have chronic illnesses have health care needs that extend beyond what has been considered to be "medically necessary" acute care. A broader concept of health would ensure a rightful place in the health care system for preventive, rehabilitative, educational, and health promotional services.

# Comprehensive Health Benefits Package:

Basic health care for all must extend beyond medically necessary acute care services to include services that prevent deterioration, increase functional capacity, and increase quality of life. A comprehensive health benefits package should include:

- preventive and diagnostic services, health promotion, and education services;
- rehabilitation services, including audiology, occupational, physical, respiratory, cognitive, psychosocial and behavioral therapies, speech and language pathology, and recreational therapy;
- mental health, counseling, and substance abuse services;
- alternative/augmentative communication and other assistive devices, along with durable medical equipment;
- habilitation services;
- personal assistance and independent living services;
- short- and long-term home and community-based services; and
- short- and long-term care in nursing and medical facilities.

#### Prevention and Wellness Services:

People who must manage chronic disabling conditions can maintain an optimal health status and increase their functional capacities and level of independence--and thus have life quality--if they have coverage for prevention and wellness services. <u>Unnecessary medical care can be avoided</u> if people, especially those who are "at-risk" for health declines, are provided with health related services that prevent secondary health problems. For example, individuals who have spinal cord injuries and are active in physical recreation and sports have been shown through research to be less susceptible to secondary health complications that require costly primary medical interventions and hospitalizations. The most cost-effective and appropriate preventive services would include education and services that reach people with congenital, developmental, and other disabilities that are not a result of illness and injury and are associated with preventing declines in physical, cognitive, emotional, and social functioning.

While the promise of preventive and wellness services is well known, more training, research, and programs are needed. Reform measures should include monies to support training health care professionals in prevention services, and funds to support efficacy research and program development in this area of health care.

# Inpatient and Outpatient Rehabilitation Services:

The most medically and cost effective rehabilitation services that exist today in inpatient and outpatient rehabilitation hospitals and centers are not limited to physical, occupational and speech therapies. Indeed, the most effective rehabilitation services that exist today are individualized and include therapies that address psychosocial needs as well as physical functioning. This is the case in physical rehabilitation, psychiatric rehabilitation services, and in programs treating persons for substance abuse and chemical dependence. For instance, recreational therapy utilizes various interventions to treat physical, social, cognitive, and emotional conditions associated with illness, injury, or chronic disability. Recreational therapy includes an educational component which helps people become more informed and active partners in their health care by using activity to cope with the stress of illness and disability, and to acquire knowledge, skills, and abilities to manage their disability so they may achieve and maintain optimal levels of independence, productivity, and well-being.

Persons who are ill or have disabling conditions require a complex set of services that extend beyond their immediate illness or injury. It is necessary for health care reform to recognize the long-term nature of managing chronic illness and disability. A broad base of habilitation, rehabilitation, and home health care services is necessary to increase an individual's capacity to prevent deterioration, increase functional skills, and manage chronic disability. Anything less will fail to ensure the most cost-effective, quality health care system for all Americans.

# **Durable Medical Equipment:**

Individuals who have been ill or must manage chronic disabling conditions can improve their functioning and prevent further deterioration when they have affordable access to assistive devices and equipment. Health care reform measures must continue to recognize the importance of such devices and equipment, but must go beyond the Medicare definition and scope of "durable medical equipment" found in section 1861(n) of the Social Security Act. That definition is too narrowly focused on immediate medical needs, thus precluding assistive technology that increases functional independence and prevents deterioration of physical, cognitive, emotional, and social abilities. Children, adolescents, and adults with significant multiple disabilities can learn to use assistive technology and alternative/augmentative communication devices, which result in significant independence, productivity, and life quality. This, in turn, has a direct bearing on the health and weli-being of these individuals. The definition of "durable medical equipment" must include assistive technology in order to have a truly cost-effective, quality health care system.

## Long-Term Care:

Health care reform must include funding for long-term services for all children and adults with all types of disabilities. These services must avoid the bias toward institutionalization that exists in long-term care and, instead, ensure an emphasis on family and community-based supports and services. Family and community-based supports and services are indeed more cost-effective, and contribute significantly to health status, functional capacity, and quality of life for persons who have disabilities that must be managed for a lifetime.

# THERAPEUTIC RECREATION AND COMPREHENSIVE HEALTH CARE

This statement has been prepared to clarify the role of therapeutic recreation services, an integral part of comprehensive health care today and tomorrow. Therapeutic recreation services contribute to the broad spectrum of health care through treatment (recreational therapy), education, and the provision of recreational opportunities—all of which are instrumental to improving and maintaining physical, cognitive, emotional, and social functioning, preventing secondary health conditions, enhancing independent living skills, and overall quality of life.

Recreational therapy utilizes various interventions to treat physical, social, cognitive, and emotional conditions associated with illness, injury, or chronic disability. Recreational therapy includes an educational component which enables individuals to become more informed and active partners in their own health care by using activities to cope with the stress of illness and disability. Furthermore, these services assist individuals with managing their disabilities so they may achieve and maintain optimal levels of independence, productivity, and well-being, and enter/re-enter the mainstream of community life.

Therapeutic recreation services also include the provision of recreational opportunities (e.g., wheelchair sports, exercise and fitness programs, social activities, etc.) which can minimize health care costs by allowing individuals with disabilities mechanisms to prevent declines in physical, cognitive, social, and emotional health status, and thereby reducing the need for medical services.

Therapeutic recreation services are provided by qualified professionals with training and education in therapeutic recreation/recreational therapy, and who are certified by the National Council for Therapeutic Recreation Certification, Inc. (NCTRC). NCTRC is recognized by the National Commission on Certifying Agencies. The professional certification designation is Certified Therapeutic Recreation Specialist (CTRS).

Recreational therapy is a well-established part of comprehensive inpatient and outpatient rehabilitation services. These services are found in a variety of settings depending on the needs of the consumer. Settings in which services are traditionally delivered include: freestanding rehabilitation hospitals; rehabilitation units in general hospitals; long-term care and skilled nursing facilities; comprehensive outpatient rehabilitation facilities; inpatient and outpatient mental health/psychiatric facilities; substance abuse rehabilitation facilities, home health and community settings; and residential facilities for persons with disabilities. Additionally, therapeutic recreation services are provided in communities where preventive health services are addressed by community hospitals, schools, and other human service agencies.

Comprehensive rehabilitation services have proven to be cost-effective and recreational therapy, as a component, offers a diversity of benefits to persons with a range of disabilities. A survey conducted by the Health Insurance Association of America indicated a savings of \$11 for every \$1 spent on rehabilitation. Research has demonstrated that quality comprehensive rehabilitation services reduce long-term hospitalization and nursing home stays for stroke patients. The reduction of long-term institutional stays saves the American economy \$17,000 per year per resident. In addition, research evidence indicates that recreational therapy prevents secondary disability and contributes to overall health and well-being by raising the level of life quality experienced by persons receiving these services.

Recreational therapists are included as members of the core treatment team in physical rehabilitation services in the quality care standards issued by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Recreational therapists are principal treatment team members in psychiatric rehabilitation, substance abuse treatment, and physical rehabilitation services in both inpatient and outpatient settings. In addition, recreational therapists are designated as members of the comprehensive core treatment team in standards of care for acute brain injury, post-acute brain injury, and inpatient rehabilitation issued by the Commission on Accreditation of Rehabilitation Facilities (CARF). Furthermore, the Health Care Financing Administration (HCFA) includes recreational therapy in the mix of treatment and rehabilitation services used in skilled nursing, long-term care, and rehabilitation facilities.

# STATEMENT OF THE NATIONAL ASSOCIATION FOR MEDICAL EQUIPMENT SERVICES

The National Association for Medical Equipment Services (NAMES) is pleased to comment on the "Health Security Act." NAMES represents over 2,000 home medical equipment (HME) suppliers who provide quality, cost-effective HME and rehabilitation/assistive technology equipment and services to consumers in the home.

NAMES and the HME services industry applaud the Administration for including HME services and custom devices as part of its "standard benefits package." HME is demonstrably cost-effective and persons with disabilities and the elderly far prefer to recuperate from an illness or injury at home. In addition, NAMES is extremely pleased that the Health Security Act includes a long-term care component that allows individuals with disabilities and older Americans the opportunity to further utilize HME equipment and services.

Several aspects of the Clinton plan, however, cause great concern for the HME services industry. The following issues in the Health Security Act must be addressed:

# 1. Competitive Bidding

Section 4118 of the Health Security Act seeks to implement competitive bidding for oxygen and oxygen equipment and "such other items and services" as determined by the Secretary of the Department of Health and Human Services. This provision is part of the \$238 billion in Medicare and Medicaid cuts over five years that will help pay for the Administration's proposal. The goal of maintaining and improving quality health care for millions of Americans will not be advanced by competitive bidding for home medical equipment or rehabilitative/assistive technology. In fact, our experience demonstrates that competitive bidding will reduce the provision of quality HME services for persons with disabilities and older Americans.

The provision of HME for persons with disabilities and older Americans requires an extensive services component. Providers of HME deliver much more than just the equipment — the more critical component of HME includes the services rendered to the individual users, such as: setting up the equipment; explaining how it operates; properly fitting a wheelchair's seating system to accommodate the user's particular disability; and maintaining it. Experience indicates that, where previously implemented, competitive bidding systems have not guaranteed the maintenance of such high levels of quality service. NAMES strongly believes that competitive bidding will not ensure quality HME services at reduced payment levels and could curtail access of home medical equipment to all Americans.

#### (a) The Service Component

With any competitive bidding system, the first issue to consider must be a determination of what level of services provided by HME suppliers the government is willing to purchase. Congress must be concerned that the service component — so integral to assuring patient health and safety — may diminish or disappear entirely with competitive bidding for home medical equipment. As but one example of how competitive bidding has not worked well, suppliers in Minnesota have expressed serious concern about numerous service-related problems associated with the provisions of HME by the Minnesota Medical Assistance Contracted Providers, a group of companies that have been awarded Medicaid contracts with the state. Some problems that have developed include:

- · Inadequate patient education and training on equipment;
- · Poor professional follow-up services to determine if the patient is properly using the equipment;
- · Irregular equipment checks to determine if the equipment is properly working; and
- Contracts that allow a wait of as long as 24 hours from the time the initial physician's order is received by the supplier until the equipment is delivered and setup.

Americans with disabilities and the elderly could suffer significantly under competitive bidding because access to the services inherent in providing the custom, highly specialized equipment they require likely will

diminish. NAMES estimates that the small percentage of HME suppliers who could remain in business under this type of structure would not be able to provide high cost, low margin and highly serviced equipment to all corners of the country.

An HME provider in Minnesota services approximately 100 oxygen patients, with 90 of them being Medicare beneficiaries. Typically, the company provides an average of three after hours (evenings and weekends) calls per week to provide emergency service to the patients or new setups. If these patients were not serviced adequately and on a timely basis, costly hospitalizations would result. Often, new orders for oxygen in the home are initiated from an urgent care clinic or hospital emergency room, thereby avoiding hospital admission. Under competitive bidding, a rapid response time by a limited pool of providers would not be possible, leading to additional and more costly hospital admissions.

One patient's story exemplifies this problem: Charlotte is an elderly woman on Medicare. Both her body and her mind are deteriorating. Stricken with emphysema, Charlotte is dependent on the oxygen fed to her through a concentrator. She also suffers from frequent memory lapses. Often, Charlotte forgets everything about her life-sustaining equipment — everything but the phone number of her medical equipment supplier in Minnesota. Sometimes two or three times a week, Charlotte experiences a "medical equipment crisis," having forgotten how to operate her oxygen concentrator. Fortunately, these emergencies are remedied quickly by her medical equipment provider, located only two miles from her house. Within minutes, Charlotte's oxygen flows again. Under a competitive bidding scenario, Charlotte's provider could be located hours away. The costs of Charlotte's crises would be much greater — exorbitant hospital admission fees or, worse yet, death.

#### (b) Complexity of Implementing Competitive Bidding

Competitive bidding for certain HME items already has been tried and subsequently abandoned in a number of states. Even more enormous complexities would arise in dividing the entire nation into multiple and reasonable service areas, since few HME suppliers provide all possible HME services. The following consequences likely could result:

- Rural communities across America would be most affected, as beneficiaries would not have access to hundreds of medical equipment and supply items;
- Successful bidders for oxygen and other major products would not be able to provide reasonable coverage for the delivery of the full spectrum of HME items and services to all of the areas and regions throughout America; and
- Successful bidders would have to deliver a significant portion of the required equipment. Smaller companies that provide and service less costly and lower volume items simply would not be able to continue to provide delivery of these items. They subsequently could cease to exist. Severe delivery delays for equipment and services by larger companies that may maintain their presence through the bid would occur because of the high cost of delivering HME beyond reasonable distances, across urban areas and throughout rural areas. Thus, hospital discharges to the home would be delayed and hospital admissions would increase as patients wait for the required equipment to be cared for at home.

# (c) Cost of Competitive Bidding

Under competitive bidding structures that currently exist for oxygen in the Veterans Administration (VA), equipment delivery times range from 24 hours to 72 hours from the time an equipment order is initiated. This significant delay results from permitting the bidder who has the contract enough time to cover a large geographic area and be as efficient as possible in order to stay in business under the lower competitive bidding rates.

- With delivery delays, we expect to see an increase of overall health care delivery costs. Patients
  will experience delays in discharge (which will severely disrupt the current DRG structure under
  Medicare Part A), while waiting for service.
- Service levels will deteriorate significantly. Follow-up visits by health professionals that facilitate
  ongoing and thorough patient/physician/provider interaction, patient/caregiver education and
  monitoring of adherence to physician orders will be eliminated or considerably reduced.
- Emergency service (24 hours per day) will be compromised because of the distance that
  companies typically travel to care for patients under a competitive bidding structure. Routine
  maintenance checks of equipment servicing will be cut back due to cost constraints, causing
  concern for patient safety.
- If only one readmission for acute exacerbation of the pulmonary condition known as "COPD" occurs, which otherwise could have been avoided by providing the high level of in-home service that exists today, the cost of that Medicare admission to the federal government will exceed the savings achieved under competitive bidding for that individual patient for several years.

Competitive bidding is known to work poorly both for the Defense Department and the VA, where this technique already is used on a large scale, similar to what Medicare would require. Some VA hospitals have experienced quality deficiencies documented by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), due on average to the poor quality of services provided by VA competitive bidding contract winners. The VA, once acquiring a signed contract in certain states, has monitored providers for provision of services, only to find they have little awareness of appropriateness of equipment; various types of equipment; safety features of equipment; and current pricing of equipment. Under the Health Security Act's competitive bidding proposals, similar, if not greater, problems in access and quality would be expected.

British Columbia, Canada, has had a competitive bidding process for HME services in place since

November 1991. There, the government uses a scheme of establishing a "preferred" provider based on the
lowest bid and up to 2 "approved" providers based on the next lowest bid in each health unit (7 units in

British Columbia). Typically, this system allows for: a delay as long as 48 hours to set up new patients, from
time of initial order; a lengthy three-year bid period with the government option to renew every year if the
provider is not performing based on confirmed complaints; concentrators, liquid oxygen systems, portable
systems and contents to be bid and paid for separately, with contents based on actual usage; government
mandates on patient follow-ups/assessments done only every 6 months as a minimum; government mandates
that require concentrators to be maintained at only a minimum of every three months. This system has
experienced an overall decline in service levels because patients have remained in hospitals longer. Service
delays and hospital admissions more than likely have increased because of minimal patient/provider/

physician interaction. Such minimal service levels are far from what current American practice allows and, we submit, are therefore unacceptable.

# (d) Competitive Bidding Studies

In 1986, the General Accounting Office (GAO) studied eight Health Care Financing Administration (HCFA)-initiated competitive fixed-price contracts, conducted on an experimental basis for Medicare carriers and intermediaries. After examining seven of the contracts, GAO made the following observations:

- A major change in the method of contracting used in the Medicare program is not justified because the competitive fixed-price experiments have not demonstrated any clear advantage over cost contracts presently used to administer the program;
- The frequent use of this method of contracting could increase Medicare administrative problems, including the risk of poor contractor performance; and
- · There is potential for disrupted service.

GAO concluded that HCFA in fact lost money on four of the contracts (Medicare - Existing Contract Authority Can Provide for Effective Program Administration, GAO/HRD-86-48, April 1986).

Although HCFA has studied and recommended the implementation of competitive bidding for many years, Congress repeatedly has wisely rejected the agency's proposals on this issue. Between 1985 and 1990, Abt Associates of Cambridge, Massachusetts, was under contract with HCFA to evaluate competitive bidding as a method of purchasing home medical equipment. One Abt Report summary stated that:

"Competitive bidding processes per se will not necessarily result in lower Medicare costs (service and administration) for DME or clinical laboratory services in comparison to other available reimbursement methods. The ability of competitive bidding to realize savings for Medicare, while safeguarding quality, depends critically on the design, implementation and subsequent administration of the bidding system adopted. This review of the empirical literature has raised a host of issues for DME and clinical laboratory competitive bidding demonstrations, while providing considerably fewer findings that can be put forward with confidence."

From these studies alone it is clear that competitive bidding on HME should not be an option for the Medicare program. NAMES does not oppose *competition* in the health care marketplace, provided that the quality of patient care and services are maintained. However, no data have been presented to indicate that inadequate competition exists today in the HME services marketplace. Indeed, the increasing number of new entrants indicates that competition is flourishing. Based on the accumulated evidence that demonstrates the inadequacies of competitive bidding and because of the adverse impact that such a system would have on persons with disabilities, HME providers and the entire health care system, NAMES strongly opposes competitive bidding for home medical equipment and rehabilitation/assistive technology services.

## 2. Freedom of Choice

Especially important, all Americans should have freedom to choose their health care providers. Because the Health Security Act encourages health plans to operate as efficiently and cost-effectively as possible, health plans theoretically could contract with just one provider in a given field. Such a practice would limit the choices of available providers from among which consumers could select. HME suppliers from whom

consumers already may have received prior care or whose companies are closer to home could be closed out.

There is general consensus that whatever shape health care reform takes, consumers and purchasers of health care should be permitted to exercise free choice based upon quality, cost and patient satisfaction.

There can be no meaningful consumer choice, however, without market access by truly competing providers of care. NAMES already is beginning to see situations develop where consumer choice is being severely limited primarily because some HMOs will contract only with one HME supplier. Our concern is that reducing the number of providers in a given field will result in decreased competition, eventually driving up prices, while diminishing quality of care. No single provider can adequately cover as large a geographical and populated area as envisioned in the Health Security Act. Suppliers vigorously oppose the concept of a competitive bidding system for HME items that essentially would lead to diminution of services and quality.

NAMES strongly supports the following "freedom of choice" principles:

- No provision in the final health care reform plan should be constructed to allow monopolization, attempted monopolization, conspiracy to monopolize or other restraint of trade prohibited under the existing antitrust laws;
- Any proposed "health plan" must select participating providers through a competitive process
  using objective criteria, including quality, price, services and patient satisfaction; and publish a
  description of any competitive selection process in advance to permit all interested providers a fair
  opportunity to participate;
- States may not limit or prohibit competition among providers to participate in a health plan by granting any antitrust exemption;
- Integrated health systems should be prohibited from acquiring or maintaining control of more than 20 percent (20%) of the business in a particular health care product and geographic market; and
- Providers seeking the protection of "safe zones" under the new Justice Department guidelines and Federal Trade Commission rules must publish a notice in a local newspaper describing the nature of the project.

NAMES recommends that the final health care reform legislation should provide incentives for health plans to contract with as many providers as necessary to meet the needs of the community. At the very least, there should not be any disincentives in the system to allowing full provider participation. As well, administrative simplification of forms and the processing of reimbursement claims would help eliminate some of these disincentives.

Finally, the Health Security Act would allow consumers to choose health plans based on price and quality. Because quality measurement and determination are such important issues, NAMES proposes that only tested methods of quality assurance and quality improvement be used. These methods might include requiring a full range of HME services available, outcome measures, as well as patient satisfaction monitoring. Providers and consumers alike should have substantial input on determining or defining quality.

## Conclusion

One solution to rising health care costs that emerges as an efficient, affordable and compassionate option is HME services as part of home care. HME suppliers meet the needs of a wide range of individuals

who require medical equipment and services in their homes. Suppliers not only provide many of the more "traditional" items of equipment such as those envisioned when the Medicare Part B "DME" benefit was first adopted as part of the Medicare law in 1965, but also provide a vast array of highly specialized and advanced services, such as infusion therapy for the provision of antibiotics and chemotherapy, oxygen and ventilator systems, and advanced rehabilitation equipment and assistive technology. Comprehensive health care reform should establish no impediments to the use of home care and HME services that are currently available or to the enhancement of care in the home and other non-institutional settings.

# STATEMENT OF THE NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS

Supporting The Health Securities Act and Exiting School Based Pupil Services Programs to Better Serve All Children, Youth and Families, Including Those Challenged by Disabilities

The Health Security Act is designed to provide universal, cost effective health coverage. Its aim includes reducing waste, improving accountability and prioritizing need. Prevention is a key goal. The Act supports building upon existing services rather than reinventing them. There is a strong focus upon children and also upon mental health.

The National Association of School Psychologists, (NASP) and its 16,000 members stongly endorses the Health Security Act and urges Congress to pass this legislation so that the President may sign this legislation into law in 1994.

We strongly support the Act. In particular, we endorse its emphasis upon the special needs of children, prevention, mental health, school based services and its recognition of, and sensitivity to our nation's cultural, ethnic and language variability. We applaud its focus upon community needs and the needs of special populations, including those at risk and those whose disabilities hamper their learning, wellness and other life functions.

The Health Security Act includes some provisions for delivering health and mental service to children and youth with disabilities. However, the Act remains unclear as to how these services will be delivered to students in school.

Therefore, NASP recommends that the Act be amended to more clearly address the elements of prevention, school-wide services as well as services necessary to meet the complex developmental needs of today's student population, including children and youth at risk for disabilities. Services must be systemic and enable the long-term support many students require to maximize their functioning, quality of life and employability.

Furthermore, if disabilities are to be maximally prevented and children are to be available for academic learning, these school-wide prevention and intervention programs will be necessary to provide a variety of services to support the physical, emotional and behavioral wellness of general school populations. Title III, Subtitle G of the Act provides the guidelines for school-wide programs. It is not clear how these guidelines address the issues of services to the disabled or of integration with the existing school-based service providers.

It is important to recognize that many of the services listed within Title III, Subtitle G and other parts of the Act are services that are <u>presently being provided</u> in schools by professionals employed by school systems. Existing school-based health providers include, but are not limited to, school nurses, school psychologists, school social workers, counselors, speechlanguage pathologists, occupational therapists, physical therapists and, in some communities, school physicians. These school-based personnel also serve total school populations with an

emphasis upon those populations who engage in high risk behaviors which can result in health, mental health and drug/alcohol problems. As a group, school system personnel are listed within law as "pupil services," "related services" and "support services" as well as "health services."

# Advantages of Integrating School-based Service Providers into Health Service Plans

Integrating school-based program service providers into health service plans will increase efficiency and access to services while reduce costs. These professionals are licensed and certified to provide health and mental health education and service programs. They have established rapport with educators and the community. They understand the language of the service and program systems, including health, mental health and education. The infrastructure for their range of services is in place to supplement the broader health service goals, meeting the needs of all children. They can provide the convenient link between schools, related agencies and health plan providers. Their services are cost effective, easily monitored, evaluated and supervised. Their titles and services are identified within current Federal and state laws and policies. These advantages include:

- 1. <u>Licensure and Certification</u> is standardized and controlled by existing State agencies. States maintain continuing education, inservice training and professional standards requirements.
- 2. <u>School facilities</u> exist in every community. Regulations, policies and standards frequently are in place which require appropriate infrastructure including space, equipment, materials and secure, confidential record keeping.
- 3. The range of services includes many that meet the objectives of the Act including:
  - \* Prevention and early identification/intervention/referral
  - \* Health education and "healthy school" intervention plans
  - \* Mental health education and school-wide behavior management plans
  - \* Consultation services to teachers, students, caregivers and families
  - \* Immunizations
  - \* Emergency health treatment services/referral
  - \* Assessment and Diagnosis
  - \* Case management and coordination with other providers
  - \* Individual and group therapies integrated into the school program
  - \* Crisis treatment and intervention
  - \* Skill development/education in healthy behaviors
  - \* Parent-family education in child development, home care and abuse prevention
  - \* Systemic and environmental intervention planning
  - \* Employee assistance
  - \* Drug and alcohol education, treatment and counseling
  - \* Wellness clinics
  - \* Violence, suicide and abuse prevention
- 4. Consistency of pupil and related services noted within existing Federal laws. The Rehabilitation Act, Elementary and Secondary Education Act, Medicaid and other Federal programs recognize these professional providers as critical in the service of children through age 21. For Medicaid recipients, states have created specific "fee-for-service" schedules like those required under the Act (Title I).
- 5. <u>Convenient, cost-effective models exist.</u> School-based personnel have existing exemplary system models that could be expanded, used and modified by community-based health care management planners. Project ACHIEVE in Florida, The Primary Mental Health Projects serving most urban centers in Connecticut, several interagency programs in Ohio which utilize pooled funding, are but a few of the many examples having documented success. Children are

served in an environment where the outcomes can be observed and measured. Their productivity in learning is maintained and not disrupted by having to leave school for treatment. Pupil services and related service personnel are able to observe children within the natural environment to assist physicians and other practitioners in the evaluation of treatments, including medications. School-based services can engage the strengths of families and caregivers. They strive to be "family friendly." Programs, treatment, primary, secondary and tertiary prevention can be integrated into education to increase their impact. Health services become more effective since they are understood by teachers and other caregivers and those services are coordinated with other community based support services.

Many of these pupil services and health professionals have recommended service ratios based upon the general school population numbers as well as specific direct (caseload) service ratios. The following is a list of the ratios recommended by the related professions. These ratios are frequently based upon research and are seen as minimums rather than ideal. Higher child to professional ratios can result in poor outcomes.

Profession	Maximum Population of Children	Maximum Caseload
School Nurse School Psychologist	750 1000	225 (special) 125(severe)
School Social Worke	r 800	100 80
School Counselor Speech Lang. Patholo		40
Occupational Therapi Physical Therapist	st	40
Physician Audiologist	1000	30-50

## Issues, Concerns and Recommendations:

In support of Clinical Preventive Services, (Title I, Subtitle B Sec. 1153) we believe such services can and will reduce the number of children and youth who become disabled and who, therefore, will need more costly service plans. This is particularly true for what is termed "high risk populations" of infants, toddlers and children as well as adolescents. According to the Department of Health and Human Services, one in four of today's adolescents, (7 million) engages in high risk social behaviors that can lead to serious, long-term problems. These problems include physical injuries, addictions, pregnancies, suicides, HIV infections and homicides. These behaviors also limit hope, opportunity, graduation rates and employability. They can place long-term financial burdens upon communities, overwhelm and destroy families.

# Recommendation for Report Language:

We urge that report language acknowledge the skills and contributions school based pupil services personnel have demonstrated and that prevention programs can and do reduce high risk social behaviors, thus reducing negative outcomes for the adolescent population.

# Inclusion of Effective Program:

We urge that present, cost effective EPSDT services be supported and integrated into the Act and not reinvented.

The Act recognizes the long-term care needs of individuals with disabilities and the need to include these individuals, regardless of age, into the State plans. We remain concerned regarding the terms used in different Federal and state statutes to identify individuals as disabled. Definitions within existing laws for the same term or category vary significantly. This discrepancy between laws has nothing to do with "means tests" or severity ratings, which may be used to differentiate eligibility for specific services or support, but with the definitions themselves. This will reduce duplicative costs and prevent children and youth in need of services from being excluded from needed services due to these inconsistencies.

## Recommendation:

We urge that language in the Act defining disability be consistent and cross referenced other existing legislation for children, youths and adults with disabilities.

The Act recognizes that children and youth with Mental Illness have serious health needs that, if untreated, will result in costly consequences for individuals and communities. These consequences include increased crime (60% of youth identified as seriously emotionally disturbed are arrested within five years of leaving school. Office of Special Education Programs, 1993), high unemployment, high drop-out rates and drug abuse rates. The Act recognizes the need for early identification and treatment as well as community alternatives to expensive residential placements and hospitalizations. The Act also supports, through project grant incentives, the integration of public and private systems for demonstration projects for mental health and substance abuse disorders (Section 3502).

## Recommendation:

We urge that similar language be included in the provision of mental health and other services for children and youth and that public schools and education agencies be included within the scope of "public systems."

Furthermore, states will need to develop mechanisms (including memorandums of understanding) to make sure that school-based mental health providers are counted within the state report and that they supplement regional and corporate alliances.

### Serious Concern:

We urge that the <u>mental health coverage limitations</u> be reviewed as to their possible very negative impact upon children and youth with scrious emotional disturbances as well as other children and youth with disabilities who may have related acute emotional problems or a dual diagnosis, including emotional disabilities (found in about 30% of children with disabilities).

Recommendation: Mental health coverage should equal that of physical health.

The Act creates a phase-in plan to provide comprehensive services by the year 2001. However, we must ask: Can we afford to wait until 2001 before appropriate mental health coverage is available? How many tax dollars will be spent to arrest and house the system's failed piecemeal intervention's failures over the next seven years. How many lives will be lost to violence and suicide that could be productive lives if treated and made ready to learn and contribute?

The present limitations in services, be it outpatient, day-care or inpatient, are arbitrary and may prevent effective evaluation of what works to meet the specific needs of each individual child. Although the Act provides coverage for a broader range of options than any existing policies, it may not provide the proper mixture of services for a long enough period of time to create the desired results. This is particularly the case for children and youth who have multiple disabilities and menual health needs compounded by drug or alcohol abuse. This complex of problems is common (30%) among high-risk populations who suffer from mental and emotional disabilities.

Furthermore, a classical <u>"fee-for-service"</u> model may continue to block the wrap-around service plans these youth require for positive outcomes.

## Recommendation:

If these less-than-appropriate service limits remain in the Act, then language must be placed within the Act so that children with mental illness will not be prevented from having the needed in-school psychotherapies at the level of intensity that can be made available to them under IDEA and Medicaid and that such intensive supports are not counted against their yearly limits upon mental health treatment.

The Act deals with School Related Health Services (Title III, Subtitle G) through a special section and funding mechanism. There are strengths to this proposal in that it recognizes that schools are frequently the center of the community for children and families. Education can and should play a major role in prevention. Many of our related organizations within the National Alliance of Pupil Service Organization support the "Healthy School" plans being developed by school health coalitions and such organizations as the National Association of State Boards of Education.

## Recommendation:

The provisions of Part G need to be revised to include coordination of services with existing school based and school-linked services noted above which may be provided under present entitlements or discretionary funding. We also urge that as states utilize this permissive component of the Act, incentives are given for the significant preventive efforts that this section is designed to provide. States which do not take advantage of this service integration and prevention program should be required to justify their decision not to participate. Outcome measures may also become an incentive for states to integrate services into the schools. A state-by-state report card of progress may assist each state in seeing the long-range cost savings of school-based prevention and intervention programs.

We are also concerned as to how this and other sections of the Act will interface with the existing services provided under state laws, ESEA Chapter I and IDEA. What will happen to the EPSDT programs? Most of these laws and several state policies have the same goals as part of this Act. How will we achieve effective integration?

## Specific Recommendations For The Inclusion Of Existing School-based Services

The following specific additions are recommended to enhance coordination and integration, reduce duplication, and strengthen the recognition of the needs of children and youth whose disabilities impede education, employability and other important life functions. (Additional language is underlined.)

Sec. 3601 Purposes

- (5) To motivate youth, including youth with disabilities, and
- (6) To improve the knowledge and skills of children and youth, including those with disabilities,

Sec. 3602 Definitions

- (4) The program promotes personal responsibility for a healthy lifestyle and provides the knowledge and skills necessary to adopt a healthy lifestyle, including teaching the legal, social, mental, and health ...
- (10) The program demonstrates how it will utilize existing professional resources and pupil services programs to prevent duplication and waste, and to increase efficiency and coordination among education and prevention programs.

Should Section 3612 specifically exclude waivers of the protection of IDEA?

Sec. 3621 Application for Grant

(1) ... and the States school improvement plan, if any, under Title III of Goals 2000: Educate America Act(.) and other Education laws, including the Individuals With Disabilities Education Act.

(2) A description of how the State education agency will collaborate with the State Health agency ....., including coordination of existing health education and pupil services programs and resources.

Sec. 3635 Subgrants to Local Education Agencies

(b) (6) Poor daily attendance.

Sec. 3671 Application for Grants

(2) ...health education and pupil service programs.

(4) ... to reduce barriers to implementing comprehensive school health education programs and how these programs will integrate existing staff and resources into the program to improve efficiency and prevent duplication and reduce cost.

Sec. 3682 Eligibility for Grant Development and Operation Grants

(b)(2) Participation A partnership described in paragraph (1) shall ... involve broad based community participation ... teachers, <u>pupil services</u> and other public school ...

Sec. 3684 Grants for the Development of Projects

(b)(NEW 3) The development of cooperative agreements with State and local eduction agencies to include existing pupil services programs in the planning and provision of school health services to reduce costs and maximize quality outcomes.

(Renumber other subsections of 3684 (b) making present (3) #4 ...)

(d) (3) An explanation of how the applicant will integrate its services with those of other health and social services programs within the community, including pupil services programs in education agencies.

Sec. 3685 Grants for Operation of Projects

(b)(5) Linkage of individuals to health plans, community health services, school-based pupil health and mental health services and social services.

(d)(1)(E) Health and social services, <u>school-based mental health services</u>, <u>and</u> counseling services ...

(d)(5) The applicant has ... in order to insure that its services are accessible to the maximum number of school age children and youth in the area, including those with disabilities, ...

The National Association of School Psychologists believes that school-based health care can become an efficient, integral part of the community school when existing services are placed in the equation and additional services are designed to supplement and not duplicate what already works. NASP also urges that community leaders responsible for planning and

implementation recognize that health education and program services must also be integrated so that, whenever possible they can evaluate both systemic problems and service needs.

Many persons within the pupil services team are expert in preventive education, consultation to teachers and caregivers, as well as providers of direct services and case management. School psychologists are trained in measurement of outcomes and evaluation of service interventions, a necessary component to determining the effectiveness of both health education and service plans. The impact upon reducing unhealthy high-risk behaviors, including violence can improve all educational outcomes, including Goals 2000.

# STATEMENT OF THE MOST REVEREND JOHN H. RICARD

My testimony today is drawn primarily from my past ministry as a pastor in poor parishes in Baltimore and Washington, and from my experience as a counselor and social worker in these communities. It also reflects my current responsibilities as Chair of the Domestic Policy Committee of the United States Catholic Conference.

Last June, the U.S. Catholic bishops unanimously adopted a major resolution to guide our approach to health care reform. I would like to share the basic message of that resolution and provide some thoughts on a few related areas:

- Principles and Potential of the Catholic The Community in this Debate Essential Priorities for Reform
- Application of our Principles to Four Specific Areas of Concern

#### THE PRINCIPLES AND POTENTIAL OF THE CATHOLIC COMMUNITY IN I. HEALTH CARE

I believe no community has more at stake or more to contribute to this debate than the Catholic community. It is important to say at the outset that we are a diverse community of faith, not a political interest group. Here in Washington, the battle over health care reform is being driven by political resources — money and power. We bring different assets which can help shape the debate. Let me briefly mention three particular resources we bring: strong convictions, broad experience, and a capacity for advocacy.

- First, we bring to this debate a set of strong convictions on <u>fundamental values and principles</u>. The Scriptures and Catholic social teaching contain key values and principles to guide our health care advocacy. Let me briefly cite four key principles:
  - 1. The first principle is a consistent commitment to human life and human dignity. In our tradition, the human person is the center. We measure every policy or proposal by whether it protects or threatens human life, whether it enhances or undermines human dignity. Our Church teaches that every human being has the right to life and to the means for protecting and sustaining life, including adequate health care. This is the teaching of Pacem in Terris and of the U.S. bishops' resolution on health care.

In our tradition, health care is not a product or commodity -- it is a basic right, an essential safeguard of human life and dignity. We believe access to adequate health care coverage should not depend on where someone works, how much their parents earn or where they live. When millions of Americans are without health coverage, when rising costs threaten the coverage of millions more, when infant mortality remains shockingly high, the right to adequate health care is seriously undermined and our health care system is in need of fundamental reform.

- 2. A second key principle is our option for the poor and vulnerable. We are called to measure a society by how it treats the weak and powerless. We look at health care "from the bottom up." For us, health care reform should be judged not by how it treats doctors or insurance companies, the well-off and powerful, but by how it serves the poor and unserved, the unborn and the undocumented. This measure of reform provides a unique perspective on the real priorities for health care reform.
- 3. A third key principle is the traditional principle of stewardship. We recognize there are limits on our national resources and we know the impact of rapidly rising costs in health care. Our nation is morally obliged to address the waste, duplication and unrestrained costs of our system and its impact on individuals, families, institutions and the entire society. Stewardship demands effective efforts to restrain rising costs without jeopardizing needed health care for all our people.
  - 4. A fourth key principle is our commitment to the common good. In the midst of the partisan battles to come, and the inevitable clash of powerful economic interests, we believe the basic test will be how reform serves the good of the whole nation, not the narrow interests of the powerful or the partisan needs of political factions.

These four principles are useful starting points for an ethical evaluation of reform. They help the Catholic community bring a moral perspective to an intensely political debate and offer an ethical framework in an arena dominated by major institutional interests.

B. In addition to these fundamental principles, we also bring <u>broad experience</u> as <u>providers</u> and <u>purchasers</u> of health care. Aside from government itself, no institution in American life is more involved in so many aspects of health care.

The Catholic community is a <u>major provider</u> of health care. Religious communities and dioceses operate 600 hospitals, 300 long term facilities, and hundreds of clinics and other health ministries. We are the largest nonprofit provider of health care, serving tens of millions of patients each year.

The Catholic health care apostolate is not only an essential ministry of our Church -- it is a major contribution to the nation. Catholic providers are on the front lines, which is why the Bishops' Conference works closely with the Catholic Health Association in our policy development and advocacy.

We are also a <u>major purchaser</u> of health care. Catholic institutions provide health care coverage for hundreds of thousands of employees and their families. We know in real

terms the consequences of escalating costs. Our ministry and programs are squeezed and our services reduced because of the rapidly rising costs of health care.

We are also a community that <u>picks up the pieces</u> of a failing health care system. Children without care, families without insurance, the sick without options are in our emergency rooms, our shelters and soup kitchens, parishes and schools. Our passion for reform is shaped by concrete experience. We bring a human perspective to an often abstract debate.

C. A third major asset we bring is a significant capacity for advocacy. We are not new to this debate. Seventy-five years ago the American bishops called attention to the health needs of our nation. For decades, we have advocated sweeping reform. While some recent converts to reform -- groups of doctors, insurance companies and others -- were calling national health insurance "socialized medicine" we were testifying on behalf of reform in Congress.

We have a constituency. We are present in every state and congressional district. We bring expertise and credibility rooted in our experience and values. We meet needs in urban, rural and suburban communities. Our community of faith crosses racial, ethnic, ideological, economic and political lines. Because of our size, presence and principles, we can make a significant impact on the health care reform debate.

### II. ESSENTIAL PRIORITIES FOR REFORM

We seek to offer principled and positive advocacy for health care reform that reaches out to the unserved, protects the unborn and contains costs. For years, our Conference has been working with others to apply these principles. We have developed and shared our criteria for reform. We have met with the President, the First Lady and White House officials as well as key members of Congress. We are on the Hill, working with coalitions, and seeking to advocate the four priorities identified by the bishops last June. Those priorities are:

1. Priority Concern for Poor/Universal Access.

Health care reform must put the needs of the poor and unserved first. Implementation of universal access must not be delayed, since coverage delayed may well be coverage denied. We do not support a two-tiered health system since separate health care coverage for the poor usually results in poor health care. Linking the health care of poor and working class families to the health care of those with greater resources is probably the best assurance of comprehensive benefits and quality care. Universal access must be a centerpiece of reform. Particular concerns for us are coverage for the uninsured and undocumented. Health care reform must be clearly measured by how it improves care for those now without coverage. It also should be judged by whether it improves or worsens care for undocumented immigrants. Coverage of undocumented workers is important not only for moral reasons but also for public health and cost containment reasons.

2. Respect for Human Life and Dignity.

Health care reform must protect life, not threaten to destroy it. We believe that it would be a moral tragedy, serious policy misjudgment and major political mistake to burden health care with abortion coverage. On this key issue

public opinion is with us. For example, a <u>New York Times</u> poll has concluded that Americans oppose abortion coverage in a national health care plan by a three to one margin. Recent Congressional votes on the Hyde Amendment indicate that both the House and Senate are unwilling to reverse federal precedent on abortion funding.

These are encouraging signs that neither the American people nor Congress want to fund abortions through health care reform. Ironically, advocates of abortion insist in the name of "choice" that all Americans should be <a href="compelled">compelled</a> to fund all abortions.

It is clear that Congress will decide whether health care reform will serve as a vehicle for the expansion of the proabortion agenda. There are already signs of a bipartisan movement to eliminate abortion from the basic benefits package. Even some "pro-choice" legislators acknowledge that there is something fundamentally wrong with coercing pro-life Americans to pay for the destruction of unborn children. However long it may take to eliminate the violence of legalized abortion from our society, pro-life citizens should not be forced to pay for this destruction and abortion on demand should not be made an integral part of health care.

The sooner this burden is lifted, the better for the cause of reform. It is both morally wrong and politically unwise to insist that needed health care reform be burdened with abortion, which divides the nation so profoundly, and to compel millions of people to fund what they believe is destruction of life, not healing and health care.

3. Pursuing the Common Good and Preserving Pluralism.

Health care reform must not be undermined by special interest conflicts or by the resistance of powerful forces which have a major stake in maintaining the status quo. We believe the debate can be advanced by a continuing focus on the common good and a healthy respect for genuine pluralism. A reformed system must encourage the creative and renewed involvement of both the public and private sectors, including voluntary, religious and nonprofit providers of care. It must also respect the religious and ethical values of both individuals and institutions involved in the health care system. We are deeply concerned that Catholic and other institutions with strong moral foundations may face increasing economic and regulatory pressures to compromise their moral principles and to participate in or subsidize practices inconsistent with their commitment to human life. There must be strong conscience clauses and other protections so that Catholic and other institutions, both health providers and employers, can serve the undocumented, protect unborn life, and follow their religious teachings.

4. Restraining Costs.

In this area our policy prescriptions are less specific, but our urgency is still great. Any acceptable plan must include effective mechanisms to restrain rising health care costs. By reducing health care inflation we could cut the federal deficit, improve economic competitiveness, and help stem the decline in living standards for many working families. Without cost containment, we cannot hope to make health care affordable and direct scarce national resources to other pressing problems which, in turn, worsen health problems (e.g., inadequate housing, poverty, violence, crime, joblessness and poor education). Containing costs is a crucial task if we are to avoid the growing pressure for rationing that raises fundamental ethical and equity

questions. The poor and vulnerable must not be denied needed care because the health system refuses to eliminate waste, duplication and bureaucratic costs.

We are concerned also that a reformed system, which we have advocated for so long, must take into account the fiscal constraints on and the charitable mission of religious and other nonprofit organizations and institutions which, in some cases, could be unduly burdened by the costs associated with health care reform. We would hope that nonprofits, including religiously affiliated institutions, would be treated fairly in any health reform initiative.

As the Catholic bishops said last June, "the best measure of any proposed health care initiative is the extent to which it combines universal access to comprehensive quality health care with cost control, while ensuring quality care for the poor and preserving human life and dignity."

Our criteria emphasize the need to protect the unserved, uninsured and unborn. We seek to bring together our principles and our experience in a positive and consistent case for health care reform which enhances the life and dignity of all.

It is not our role to be partisan allies or adversaries of this or any Administration. We welcome the Administration's leadership and commitment to reform. We applaud its proposed steps toward universal access and its emphasis on prevention and security. However, we are concerned about the recent changes which may delay or diminish the commitment to universal access. We deplore its efforts to link health care with abortion. We are now assessing how well the proposed legislation and its financing proposals measure up to the criteria we have outlined.

Likewise, we are at this time neither supporters nor opponents of the alternative plans offered by others, one as comprehensive as the Administration's plan and others less sweeping. We welcome these initiatives and look forward to participating in the debate. We are concerned that several of the major alternatives are not clear about their commitment to universal access and share the defects of the Administration's plan in their treatment of the unborn and undocumented.

### III. SPECIFIC AREAS OF CONCERN

Our commitment to universal access and our priority concern for the poor lead us to evaluate any plan based on the extent to which it provides for the special needs of vulnerable populations and the means necessary to enable them to achieve genuine access to the health care system. Among the most vulnerable populations are the undocumented and migrant workers, the unborn, the disabled and low income workers. We would like to call your attention to some of the ways in which genuine universal access for these vulnerable populations might be better assured through national health reform.

### The Unborn

One of our essential priorities is a commitment to ensure that real health care reform protects and enhances human life and dignity. Neither the violence of abortion and euthanasia nor the growing advocacy for assisted suicide is consistent with respect for human life. When destructive practices such as abortion are seen as part of "health care" alongside genuine acts of healing, the very meaning of health care is distorted and threatened. A consistent concern for human dignity is strongly demonstrated by providing access to

quality care from the prenatal period throughout infancy and childhood, into adult life and at the end of life, when care is possible even if cure is not.

Precious health care resources must not be spent for the destruction of human life. We believe those resources should be devoted to enhancing prenatal care services for all pregnant women. Recent improvements in pre-natal care services for Medicaid recipients should be extended to the entire population of women, providing the same important benefits in terms of maternal and fetal health and cost containment. Inclusion of case management, risk assessment, nutritional counseling, health education, psychosocial counseling, home visiting and transportation in the benefits package would help promote personal responsibility and cost-effective preventive care.

2. Undocumented and Migrant Workers

A major failing of all current health reform initiatives is their failure to extend coverage to all persons residing in the United States, regardless of their immigration status. Coverage of undocumented and migrant workers is important not only for moral reasons but also for public health and cost containment reasons.

It makes no moral sense to exclude them from coverage, since health care is not a commodity; it is a basic human right flowing from the sanctity of human life and the dignity belonging to all persons. It makes no health policy sense to leave uncovered a population which will continue to require and receive care in the most extreme and expensive circumstances, and whose precarious health status will jeopardize the health of the citizens with whom they live. Contagious diseases like tuberculosis do not check for immigration status.

Exclusion of the undocumented undermines not only the public health but also the cost containment goals of health reform. Because undocumented immigrants will not be eligible for basic or preventive care, they will likely end up in the emergency room to be treated for conditions which could have been treated less expensively through the regular health care system. The children born to undocumented mothers denied access to prenatal care will be born at greater risk of low birth weight and birth defects, preventable risks with medically costly consequences.

Fairness dictates that undocumented workers be covered by the health plan along with others in this society. Undocumented workers are interested in working. They pay taxes as well. Federal, state and local taxes affect undocumented workers and their families just as they do citizens and permanent residents. Yet, under the President's proposal, the undocumented cannot benefit from a health plan financed in part by their own tax remittances.

In the absence of such coverage the institutions which have historically provided uncompensated care to these populations will continue to do so even after reform, but they must be assured adequate support from state and federal funds to sustain their mission. If this does not happen many institutions which traditionally have provided care to the poor and vulnerable, many times using their own resources, will cease to exist.

Furthermore, mobile populations like migrant farmworkers must be ensured access to more than emergency and urgent care services at rates which are affordable for such workers. Migrant health clinics and other clinics which serve immigrants in urban areas will see their funding levels decrease under the Administration's plan at the same time that they become the only avenue for care for undocumented immigrants and migrant workers who cannot establish eligibility for a Regional Health Alliance through their residence in a state. Besides decreasing the level of funding for these sources of medical care in underserved areas, the plan fails to provide a secure source of funding, since the actual level of financial support will be determined by the annual appropriations process in Congress.

Finally, by explicitly excluding undocumented immigrants from the health care system, the Administration's plan is likely to engender and exacerbate discrimination against immigrants and U.S.-born Americans who may be perceived as immigrants because of their ethnic appearance, surnames, or accents. Health services may be delayed or even denied to persons because of uncertainty about their status or the validity of their documents. We also have concerns about the Health Security Card and the risk of it becoming a de facto national "ID card."

It is short-sighted to pretend that omitting a class of needy people from the health plan does anything other than exacerbate a situation and short-change people who are already severely marginalized in this society.

## 3. The Disabled

Section 1123 of the Administration's plan, Outpatient Rehabilitation Services, continues to be limited to services which restore function or minimize limitations on physical and cognitive functions as a result of an illness or injury. It also permits continuance beyond 60 days only if functioning is improving. Such limitations do not adequately address the need for rehabilitation for congenital disabilities and its role in preventing deterioration.

In addition, there are no specific protections for disabled individuals who cannot afford the co-payments associated with regular health care visits necessitated by their disability, or the buy-out payments needed to pay for specialists not included in the average or low-cost health plans.

## 4. Low-income Workers

The Administration's bill promotes affordability by limiting co-payments for persons receiving cash assistance, i.e. AFDC and SSI. There are strong public and health policy reasons for such protections. However, those persons not receiving such cash assistance, many of whom are in the workforce, are disadvantaged by the bill's failure to use income to determine the extent of low-income assistance.

While some believe that co-payments discourage excessive use of expensive medical resources, that must be balanced with the need to encourage appropriate use of cost effective primary and preventive health care. Therefore, whether or not they receive cash assistance, all low-income people should have co-payments indexed to fit low-income budgets and premiums reduced to affordable levels. Without such protections, low-income people would defer seeking care until illness deteriorates into an emergency, harming health and needlessly increasing later hospitalization costs.

We will work with the Administration and the Congress to help pass a plan that reaches out to the unserved and underserved, contains costs, respects pluralism and protects the unborn. We will apply our criteria consistently and we will work actively to pass real health care reform that respects human life and enhances human dignity.

I should note that leaders in Catholic health ministry, through the Catholic Health Association [CHA], have offered their own comprehensive and detailed plan reflecting key ethical values and their experience. It is encouraging to see some in the White House and Congress refer to this plan and note similarities to parts of current proposals. I wish the plans before the nation more fully reflected the priorities and policies of CHA's proposal—particularly in its vision of health care as a service rather than a commodity, its commitment to genuine delivery reform, its defense of all human life, its strong financing measures and impressive cost containment.

#### IV. CONCLUSION

This vital national debate is not about politics - which party gains - or about power - which interest group wins. This debate is fundamentally about children who don't see the day of their birth because their mothers lack prenatal care or because of the tragic violence of abortion. It is about families without insurance, the sick without care, and too many facing an uncertain future. As the bishops said in June:

"Now is the time for real health care reform. It is a matter of fundamental justice. For so many, it is literally a matter of life and death, of lives cut short and dignity denied. We urge our national leaders to look beyond special interest claims and partisan differences to unite our nation in a new commitment to meeting the health care needs of our people, especially the poor and vulnerable. This is a major political task, a significant policy challenge, and a moral imperative."

Senator HARKIN. The committee will adjourn subject to call of the chair.

[Whereupon, at 1:08 p.m., the committee was adjourned.]

# THE HEALTH SECURITY ACT OF 1993: EARLY RETIREES

# WEDNESDAY, MARCH 2, 1994

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 2:30 p.m., in room SD-430, Dirksen Senate Office Building, Senator Harris Wofford presiding.

Present: Senators Wofford, Simon, Jeffords and Gregg.

# **OPENING STATEMENT OF SENATOR WOFFORD**

Senator WOFFORD. Good afternoon. The crisis in our health care system profoundly affects older Americans, especially those who are, unlike me, younger than 65 and not eligible for Medicare. This group is seeing the health insurance they have depended on for years erode right before their eyes.

Today's hearing is going to focus on the variety of faults in our current health care systems which currently hurt these older Americans. We will explore how provisions in the Health Security Act aim to correct these problems, and we will ask whether any of the alternative health reform proposals now under consideration in Congress will do the job, or do it better.

When it comes to early retirees, one thing it seems to me is clear, and if anyone wants to question it, please do so today, but from all the evidence I have seen and the facts that have piled high, in this

area, some action is critical.

Right now across the country, workers who have given decades of their lives to their companies are being left out in the cold by cutbacks in their health benefits, benefits they fought for, worked for and were promised by their employers. These are people who showed up at work every day, paid their taxes, paid their dues, and often took lower wages in order to receive some peace and security in their retirement. But over the past year, more and more companies have either reduced retiree health benefits or dropped coverage altogether.

One recent study found that two-thirds of American companies plan to reduce or cut off retiree health benefits. They feel they have

no choice because their costs are out of control.

But this problem does not just hurt retirees It affects all of us. When companies cut off retiree health benefits, what they are really doing is shifting much of that cost onto the taxpayers, because

many of those older citizens will have to turn to Medicaid and

other public assistance.

Older people not yet on Medicare are especially vulnerable to the policies of many private insurance companies. Why? Because those insurance companies do not think they can make profits by covering those who are older, those who are sick, those who are the highest risk. So, far too often, this cruel logic of demographics results in real discrimination against older Americans—discrimination based on price or on availability.

The bottom line, though, is the same. More and more early retirees are in danger of being left without insurance at the very time

when they need it most.

Most of the health reform proposals being offered include language for reforming current insurance industry practices. They propose to end preexisting condition exclusions, ensure portability from job to job, and improve rating practices. But all insurance reform is not equal, as we have been learning. It is not enough to merely favor such market reforms. You have to enact a practical system for accomplishing them. That is a point that should not get lost in the details as we move forward on health care legislation.

As some of you know, I introduced legislation last spring called The Retiree Health Benefits Protection Act, which would help retirees defend their health benefits in court. The bill would require companies to keep benefit plans in place while the legal battles get argued, and it will make a real difference for thousands of retirees until we have implemented comprehensive reform that will guarantee private health insurance for every American regardless of whether they are working or are retired.

We are going to hear from a variety of witnesses today, and Senator Jeffords has just joined us, but I would just like to close by reading a few paragraphs from one witness who very much wanted to be here but, in the last days, has found that he cannot. He played a critical role in help in me and Pennsylvanians understand this issue. Let me read excerpts from the statement by Melvin

Specter.

"Honorable Senators"—as I hope we will be on this issue—"of the Labor and Human Resources Committee, this very day, perhaps at this very moment as this letter is being read to you, my wife is undergoing surgery at Shadyside Hospital in Pittsburgh. That is why I am not with you today. My wife suffers many affliction not the least of which are diabetes, hypertension, psoriasis and psoriatic arthritis—a heavy burden for a woman who is only 55 years of age."

"This is a nightmare. But there was another nightmare in May of 1993, when Sunbeam Oster Company, the successor company to Allegheny International, notified me that my retiree medical and health benefits and life insurance benefits were being canceled. The fine print stated that I had the option of continuing the medical protection for \$8,000 a year. You heard it right—\$8,000 a year."

"You cannot begin to imagine the mental anguish this cancellation has brought us—many restless nights, no sleep, buried in worry and stress. After 18 years of my working career with this company, working very hard for them, giving them everything I had, sometimes even more than was physically and mentally pos-

sible, it seemed, our world has been shattered."

"Is this the America that my parents came to, looking for a better life for themselves and their children? Our savings are being depleted by these exorbitant medical premiums which may force soon a sale of all our assets including our home."

"I would like to trade places for 1 day with anyone who does not face these problems and says that there is no health care crisis."

"Thank you for bringing this statement to the hearing, Senator Wofford. Gentlemen, the future of health care for this great country of ours lies in the hands of the 103rd Congress. I am confident that the right decisions will be reached, and the health care crisis will succumb to the reforms which are so sorely needed."

"Melvin Specter, White Oak, PA."

And today, we are going to try to get the views of some of our

fellow citizens on what those right decisions should be.

Our first panel consists of witnesses who will give their personal experiences with our health care systems as individuals who are under 65 and therefore not eligible for Medicare. I salute you.

Before I turn to the panel, my colleague Senator Jeffords will un-

doubtedly have some thoughtful words to give us.

# OPENING STATEMENT OF SENATOR JEFFORDS

Senator JEFFORDS. I will reserve most of my words for questions, especially of the second panel. But I want to commend you for bringing this issue to a hearing. It is an incredibly important one. We have seen terrible situations that have evolved for early retirees, in some cases with nothing to rely upon, and in other cases with insufficient insurance to rely upon.

But I am also troubled by the administration's proposal in some of its incentives or disincentives and will be looking at that later.

I question the rationale for the Federal Government picking up a large chunk, 80 percent, of the cost of retiree benefits, which would build in a substantial incentive to retire people early. That may be fine if you want to retire, but it would also be an incentive from a corporate perspective to try to reduce their costs and so on. So I think that is an important area that we ought to look into.

I am also worried basically about income security for individuals and especially where that would occur, to force people into early retirement before their plans had vested to the situation that they would be getting enough retirement income to go on beyond the re-

tirement years.

So those are things I will be interested in hearing about, and again, Mr. Chairman, I commend you for holding this hearing. It is extremely important that we find a rational way of taking care of the problem.

Thank you.

Senator Wofford. Our first witness will be Georgia Fitzwilliams, who is from Germantown, WI, outside of Milwaukee. Our second witness is Gerald Pickering, from Warrington, PA. And the third witness will be Elizabeth de Vries, from Manchester, NH. I look forward to hearing from all of you.

Georgia Fitzwilliams?

STATEMENTS OF GEORGIA FITZWILLIAMS, GERMANTOWN, WI; GERALD E. PICKERING, WARRINGTON, PA; AND ELIZABETH de VRIES, MANCHESTER, NH

Mrs. FITZWILLIAMS. Thank you, Senators.

I am very honored to be here today, and I would like to take this opportunity to share with you some of my personal experiences re-

garding the present health care system.

Like most Americans, my husband and I felt fairly confident that we would always have the necessary health care available to us should we need it. My husband is a 32-year veteran on our local police department and is covered under a self-insured program through the municipality. I am covered under a group plan where I work, and our six children were also covered under my husband's policy until they graduated from college or gained employment where benefits were included.

This all looked perfect from the surface, and we in fact thought it was. At that time, we were not able to see the erosion that was occurring to this perfect system. The single most disturbing issue to my husband and me, as I know it is to hundreds of thousands of people entering those golden years, is the lack of affordable

health care after retirement but prior to Medicare.

In my husband's situation, in 1999 he will have worked 36 years as a police officer and will be eligible to retire. He will be 58 years old and will not be eligible for Medicare for 7 years. The community he works for does not provide health care for employees after retirement, so we will be left to purchase the coverage on our own.

I do not object to having to purchase my own health care, but as today's health care costs continue to skyrocket, we would be forced to make a significant change in our life style, which is currently very modest. More significantly, we would be forced to make critical decisions regarding our health care based on our ability to

purchase coverage.

It is a medical fact that as we get older, our need for medical attention increases. This does not imply that we are not viable citizens because we need occasional health maintenance. You would be willing to replace the roof on your house to stop the leaks. Hopefully for most of us, we will be willing to treat ourselves in the same way. Occasional maintenance, or even a more serious health-related matter will be successfully handled because we have been well-maintained in the past. That will be a part of our aging years.

There are always those situations that require more extensive health care, but those too should also be available to us. With a health care program that understands that this is part of the aging process, we should be able to provide some assurance that the care and the health care coverage will be available. If we do not provide the ability to purchase this coverage, many of us will have to liquidate any assets we have earned, and when those are gone, the Government will be left to pay for our care. This does not make ethical or economic sense to me. Wouldn't it be better to provide affordable insurance for everyone who chooses to purchase the coverage, thus collecting the revenue from users of the coverage to pay for their own medical costs when they need it?

I have listened to people opposing change who say that we have the best system in the world, so why should we mess with it. They

claim we would lose benefits and not gain coverage. Yet in my family alone-and I know we are not alone-the present system is crumbling around us. Unless someone can guarantee any of us that we will always have available medical coverage that we can afford, we are all at risk.

Those of us who have expressed concerns about the current system and are encouraging changes are accused of bankrupting the system and piling up debt for our children. Obviously this is not our intention. I am concerned, however, as to whether our children will have affordable health care available to them under the cur-

rent system.

I also do not want to experience what my parents went through when my father suffered what became a fatal heart attack which left my mother to pay thousands of dollars for his medical care after his death. My parents owned a small business and watched their health care premiums skyrocket as my father required ongoing medical attention. The premiums were becoming prohibitive, and even with the excessive premiums, they were left to pay hundreds of dollars a month for his medication. My dad died at 68. My mother lives with a family member and has only her Social Security pension as an income. She pays \$374 for her supplemental coverage every 3 months. Because she is fortunate to live with a family member, she is able to afford the premium. Other seniors are not as blessed. Without family helping, my mother would need Government assistance because her Social Security would not cover her expenses.

Small business owners have had difficulties affording health care in the past, so I would think that some reasonable change to ensure their ability to purchase affordable health care coverage for themselves as well as their employees would be in their best inter-

est.

The opposition uses buzz words like "employee mandates" and "price-fixing" to kill the effort for change. Why aren't they offering to listen to the people whose lives are in jeopardy from the present system and working toward a mutual solution to this growing problem? Could it be that because it has not hit home for them that they do not feel the same measure of urgency? And will it take until the process of decay has reached their homes for them to see what is happening? Or is resistance to health care reform instead "politics as usual"? I hope not.

As I have said before, sickness and disease knows no bounds. It crosses all economic, social and ethnic differences, and the only factor determining whether or not one will be given a chance to overcome the illness, disease or accident is the availability and afford-

ability of appropriate health care.

Where are so many pieces to this health care puzzle? We have a tendency to view only our personal needs, while admittedly any change has to benefit all Americans. However, in the case of the so-called baby boomers, health care in the future could be in serious trouble. Unless the hundreds of thousands of people approaching retirement have health care that is affordable and available to them, we would be setting ourselves up for serious problems.

Why not give us the opportunity to control our destiny? Let us pay our way. The benefits are twofold. We would be making it rea-

sonable and affordable for early retirees to obtain medical care while they continue to contribute to the system, and we would

allow early retirees to retire with security.

Many people are faced with the situation of not being able to retire even though they are perhaps no longer a productive part of the work force. These people in most cases have given 35 or 40 years of their lives to their jobs and should be able to retire and live out their remaining years without the stress of having to hold down a job just to have medical benefits. As it is today, most early retirees and retirees in general could not afford to purchase the same medical coverage they have now. Without access to affordable health care, we encourage dependency on social programs.

Most of us are proud, hard-working people and have contributed to the growth of this country through not only our tax dollars, but our work ethic. We should not be punished for this effort, but unfortunately, the system does do just that. If we retire early, it hangs us out to dry. People who worked hard and saved some money for retirement are too often faced with having to spend their

savings and then some to get needed medical care.

It makes more sense to me to have us as viable members of society, continuing to contribute to the process. Not everyone is ready to retire at 55 or 58 or any other arbitrary age, but we are forcing people who should retire to stay at their jobs just to be assured

health care.

I do not know how many of you will have to deal with looking for affordable health care when you are ready to retire, but I know that everyone I know is facing that problem. We are not interested in another entitlement. We are in fact asking that we have the affordable health care available to us when we retire. Universal health care would provide that assurance. Instead of pointing fingers to place blame for the mess we are in, or to scrap an entire piece of legislation without meaningful discussion is irresponsible.

This issue happens to be a very important piece of the puzzle for our families' economic security and should not be left out. We all share in the success or failure of this legislation, and I am here

today to help in the success of this program.

Senators, when you gather together to vote on this or any other health care proposal, I would ask that you personalize the process by trying to feel what many Americans feel each day. Also in your deliberations, look to the future and consider what really is best for our children and what sacrifices we must make now to ensure that they are protected from the ills of a failed health care system that truly will bankrupt their futures. Thank you

Senator WOFFORD. Thank you.

Gerald Pickering?

Mr. PICKERING. Senator Wofford, thank you for this opportunity to testify about issues related to early retirees' health benefits.

My name is Gerald Pickering, and I am a resident of Warrington, PA, a suburb north of Philadelphia. I have been married for 40 years, to the same woman, I might add, and I am the father of three children and the grandfather of 10. I am 62 years old, and I am an early retiree.

After 32½ years with Unisys and its predecessor companies Univac and Sperry, I retired effective April 1, 1989. Other than a

2-year tour in the U.S. Air Force, Unisys was the only company I

had ever worked for.

Having joined Univac in October of 1956, I view myself as one of the pioneers of the computer industry. I enjoyed much success with Univac and Sperry and was promoted into management at a relatively early age. I knew and worked with the highest-level officers within the Univac division and the Sperry Corporation, and I

might add, all were very honorable people.

My assignments covered a wide spectrum of the company's business activities—defense, international, and domestic commercial programs. Though I joined the company in St. Paul, MN, my assignments caused me to relocate to San Diego, CA, to Washington, DC and Blue Bell, PA. I travelled extensively to Western Europe, Japan, Australia, Canada, Mexico and Brazil. I worked extremely hard and was away from my home and family for extended periods of time. For this, I was reasonably well-rewarded, both financially and in terms of recognition.

As the industry and the company matured, in the early 1980's, Sperry faced the need to cut costs. "Downsizing" was not a term we heard in those days, but the company did offer in 1981, 19184, and 1986 what it called "voluntary resignation incentive programs," or VRIP for short. To be eligible, the employee had to be at least 50 or 55 years of age, with a minimum of 10 or 15 years of service

with the company. The individual plans varied.

Each VRIP offered a financial incentive—so many years at halfpay. Each succeeding plan had a little less financial incentive than the previous offering, but each promised free medical insurance for the lifetime of the employee and his or her spouse, that is, a continuation of the medical plan in effect at the time of the employee's resignation, and at no charge.

I was not eligible personally for the 1981 VRIP, but I was eligible in 1984 and 1986. Although they were sufficiently attractive to merit serious consideration, in the end, I rejected those VRIPs. I was not ready for retirement. My wife, even more so, was not ready

for my retirement.

I did not have another job lined up. I liked my job at Unisys, and the pay was good, and I felt I still had room to grow within the

now newly-merged Unisys Corporation.

After the merger of Burroughs and Sperry in 1986 to form Unisys, the climate within the company changed. Although the compensation paid to management, which included myself, in the form of base pay and bonuses had never been better, a sense of anti-Sperry attitude prevailed throughout the company. So when

the company announced the 1989 VRIP, I was ready.

In announcing the plan, the company emphasized that by retiring no later than April 1, 1989, the employee was guaranteed free medical coverage for life, and at a cost of \$2.25 per month for his or her spouse. My analysis was that this benefit was worth several thousands of dollars, and it was the single most important feature that caused me to accept the 1989 voluntary retirement plan. The financial incentive included in my package was significantly less than those offered in previous plans; I received a lump sum payment equivalent to 39 weeks of salary.

As of April 1, 1989, I was 57½ years old—obviously, too young to retire. By accepting early retirement, I began to receive a pension of \$25,000 per year. Had I continued working at the same compensation until age 65, by the company's own statement, my pension would have become \$34,200 a year. Today, should I elect to draw Social Security before age 65, my Social Security benefits will be reduced by a few thousand dollars per year.

Accepting early retirees was financially very costly to me, to the tune of several thousand dollars, but it was beneficial to the company in the same amount. The cost to me was mitigated by the

promise of free health coverage.

On January 1, 1993, Unisys unilaterally terminated its previous contract with myself and all other retirees. The previous medical plans under which we had retired were canceled, and all retirees were brought into a new Unisys postretirement medical plan. The coverage of this new plan is somewhat less generous in terms of deductibles, annual maximums and percentages of expenses reimbursed, but most important, Unisys intends to fully shift the cost of the premiums for this medical coverage to the retirees.

From paying zero for myself and \$2.25 per month for my wife, the premiums for the Unisys plan were increased to \$25 per month for each of us in 1993, and in 1994, the premiums were again increased to \$116 a month each, which essentially takes \$232 per month from my already lowered retirement check. The \$116 covers, as the company says, one-third of their expenses in providing a re-

tirement health plan.

In 1995, the premiums will increase again to \$250 per month, so that the Unisys health plan will take \$500 from my retirement check each month, and this will encompass two-thirds of the company's costs. By 1996, the premiums will surpass \$400 per month for each of us, taking more than \$800 per month from my retirement check, so that the retirees will pay the full cost of the plan—and I will still not be eligible for Medicare.

For me, this is a tremendous financial burden. My health insurance costs in 1996 will consume 40 percent of my pension. For other Unisys retirees with much lower pensions, the result has already been devastating. With the increase this year to \$116 per month, many Unisys retirees have been forced to cancel their health insurance. They cannot afford food, lodging, and medical in-

surance.

I could never have considered taking early retirement had not my wife been working. My wife Joan is a schoolteacher. She is 60 years old. As an active employee, she is covered by medical insurance. But I have continued to pay to keep her covered under the Unisys plan because upon her retirement, she will have no coverage, and she will retire at age 62 before she is eligible for Medicare.

Although I have considered carefully my subscription to the Unisys health plan, to cancel the policy would be foolhardy. I have been diagnosed with diabetes. With such a preexisting condition, I would not be able to obtain account from another income.

would not be able to obtain coverage from another insurer.

When Unisys cut the health benefits it had promised to me, I was extremely angry. I joined with other Unisys retirees in a class action suit. The case was filed with the Eastern District of Penn-

sylvania, and testimony was given in late November 1993 and concluded in January of this year. Some of the plaintiffs unfortunately have already been dropped from the suit. Final arguments are to be made in mid-April 1994 and hopefully, a decision will be forthcoming in May or June.

Although I also support the President's initiative to cover early retirees not yet eligible for Medicare, there is an immediate need to protect early retirees who have already had their benefits terminated or reduced. There is no doubt that Unisys today can afford

to keep its word to its retirees.

How the judge may rule is very important to the future of health care in the United States. If the judge finds that companies are within their legal, if not their moral right, to cease and desist providing medical coverage that they promise to retirees, then it seems to me the burden that will fall on Government is awesome.

I urge Congress to consider legislation to curtail firms from promising early retirees health benefits and then unilaterally cutting those benefits. As far as I am concerned, Unisys is at least morally committed to providing these health benefits to retirees.

As an interim if not a final step, I would urge this committee to favorably vote out S. 1268 for consideration by the full Senate.

Again, thank you for the opportunity to testify on this very important issue.

Senator WOFFORD. Thank you.

Elizabeth de Vries.

Ms. DE VRIES. My name is Elizabeth de Vries. I am 63 years old, and I live in Manchester, NH with my husband Hugh.

In 1989, I started working as a secretary at a small nonprofit agency in Manchester. My employer offered a fully paid Blue Cross/Blue Shield health insurance policy which I was happy to accept.

Both my husband and I had been insured with a local HMO since 1974. I dropped that coverage. My husband continued with the HMO for about another year until they announced a new rate schedule which included higher premiums and decreased benefits, eliminating the 80 percent reimbursement for prescriptions for one.

We decided to drop the HMO and add my husband to my Blue Cross/Blue Shield policy. The cost of his coverage would be paid by

payroll deduction.

At first, we did not realize that benefits for him would not begin until 9 months later because of preexisting conditions. After approximately \$4,000 of unreimbursed expenses for medications,

copayments, and deductibles, he was finally covered.

When I started work in June, the premium rate was \$63.02. On the anniversary date in September, it rose to \$75.56. Of course, each year brought a rate increase. By 1990's anniversary date, the rate was \$164.37. My employer had continued to pay for my coverage. Then the notice came which dropped the bombshell—premiums were being increased to \$413.59 per month per person.

A small organization could not absorb an increase like that for three of its five employees. My coworkers and I decided to telephone Blue Cross/Blue Shield to ask why the drastic increase. We were told that the new rates were based on age and sex. We wrote to the Governor and the insurance commissioner. A letter from the latter explained that, yes, it was age discrimination, but it was not

illegal

At first, we tried to find alternative plans. Some we could have chosen had lower rates, along with higher deductibles and/or copayments, but none of those we checked would have accepted my husband with his preexisting conditions. We knew that any plan we chose would mean increased costs.

After considering my financial situation, and in view of the fact that I had never used any of the health services I was eligible for under Blue Cross/Blue Shield, I chose to take my chances without insurance. My husband, as a Marine Corps veteran, was able to go the local VA hospital for medical care, paying a nominal charge for

prescriptions and office visits.

I was gambling on my excellent health continuing for another few years until Medicare. I gambled, and I lost. In December of 1992, I had a heart attack. I was hospitalized for 10 days at a local hospital and was referred for additional treatment to a Boston hospital the following month. The bill from the first hospital was \$22,469.63, and from the second, \$7,926.93.

I was able to return to work after some 6 weeks at home, only to learn that my job was being reduced to part-time, 20 hours, at

the start of the new fiscal year.

Workmen's compensation did not agree that my illness was work-related, stress-induced, and denied my claim. I applied for free care at both hospitals. One application was approved; the other is still being considered.

I have not visited the doctor for almost a year now because I do not want to add to the more than \$3,000 I owe home. I still take the medications prescribed when I left the hospital, about \$130 per

month.

In December of 1993, I was laid off completely and am now on unemployment. I am actively seeking a new job, but I know that my age counts against me because of the increased cost of health

care benefits.

My husband took early retirement at 62. He could not find employment in a very difficult job market and suffers from high blood pressure and diabetes. We live in a two-family house. The rent we receive plus my husband's Social Security covers the mortgage payments. We could not get refinancing so are still paying 13.5 percent interest.

I am now hoping and praying that nothing goes wrong until June

of 1995, when I turn 65.

For many years, I have hoped to see some sign that there might be changed in the health care system in America. I have lived in other countries, and I have observed first-hand health care in England, Germany, Canada, and in the U.S. military. The appalling confusion of so many insurance plans, each with its own rules, guidelines and exclusions, is hard enough to deal with when you are healthy. Having to figure it out when you are sick is much worse.

As I have always understood it, the idea of insurance is to spread risk over a large population so as to reduce the burden on the individual. Chopping up that population into ever small groups just negates the whole concept. Rates ought to be set so that there is

enough to pay claims, cover expenses, and allow for reasonable profit. I do not believe it is immoral or evil for a business to make a profit. That is what we call capitalism, I think. But it does seem to me that there is more involved here when you are dealing with people's lives and health. So many like myself have paid into the system year in and year out and taken nothing back. Now, when we need to draw on it, the rug is pulled out from under us. That is not fair. It is not American.

With all my heart, I pray that something will come out of these hearings. We have waited a long time. When Harry Truman tried to reform health care, I was a young woman just beginning my adult life. I did not pay attention then. Such things just did not have much to do with me. That was a long time ago.

I am grateful for the hard work and uphill fights that are giving us some hope. Whatever does result will have to be better than what we have got, which for me right now is nothing.

Thank you.

Senator WOFFORD. Thank you, and I thank all three of you.

Senator Gregg, would you like to make a statement?

Senator GREGG. Are we going to questions?

Senator WOFFORD. I just wanted to give you a chance for a statement if you have one.

Senator GREGG. I will pass on that so we can proceed right to

questions.

Senator WOFFORD. Senator Jeffords, would you like to start the questions?

Senator JEFFORDS. Yes, thank you, Mr. Chairman.

Mr. Pickering, you mentioned that a lawsuit has been brought on your behalf; is that right?

Mr. Pickering, Right.

Senator JEFFORDS. And what is the status of that suit right now? Mr. Pickering. The lawsuit I refer to is for the nonunion people. You do have on your next panel someone who might well speak to the union side, Mr. Bywater. But during last summer 1993, Unisys filed a motion for summary judgment seeking to have the court rule against the retirees from Sperry Burroughs and Unisys. In other words, Unisys asked the court to rule that this case is a "nobrainer" and that it had retained the right to cut the benefits that it was promising to former employees.

The court ruled on that motion that the benefit booklets for the Burroughs plan and the Unisys plan retirees were sufficiently clear to allow the company to terminate their health benefits. But the court ruled that the Sperry retirees and the special incentives plans from Burroughs and Unisys would go to trial. So the trial has occurred, and as I indicated in my statement, testimony was

given in late November and concluded in January.

The trial brought out evidence suggesting that the Burroughs and Unisys employees were led to believe that they would receive medical coverage free for their lifetimes, and based on that testimony, we would be hopeful the court would reinstate their claims. That affects 14,000 retirees.

I am also hopeful that the appeal will move quickly and successfully, and we are looking essentially for a decision by May or June,

that time frame.

Senator JEFFORDS. Thank you.

Thank you, Mr. Chairman. I just want to say that you have put in good focus the very serious problems that our early retirees have. I again want to commend the chairman of the subcommittee at this point for bringing this to our attention, and hopefully, we will be able to work something out which will give you a fair shake whatever happens in the court trials.

Mr. PICKERING. Thank you.

Senator JEFFORDS. Thank you, Mr. Chairman.

Senator WOFFORD. Senator Gregg?

Senator GREGG. Thank you, Mr. Chairman.

It was nice to hear from these witnesses. They all obviously have very legitimate concerns. I especially appreciate hearing from Mrs. de Vries from New Hampshire, who I think made an excellent presentation and summary of her position and the concerns which she

expressed.

As I listened to the comments that were made, however, and tried to put them in the context of the bills which we are confronting and addressing as a committee, it seemed to me that almost all the issues raised by this panel can be addressed without the dramatic reassessment of the system and restructuring of the sys-

tem which would result from the President's plan.

None of the issues which you have raised require a global budget, which would lead to deterioration in quality of health care—price controls, in other words, and rationing. None of the issues which you have raised require nationalization or a group of Federal bureaucrats to take over telling your doctors what type of care they should give you when you have your physical problems, and none of these proposals require that you be limited in your choice of doctors as to whom you go to, the type of specialists you want to pursue and what institutions you wish to go to when you become sick. None of the issues which you have raised require that the Fed-

None of the issues which you have raised require that the Federal Government come in and essentially take over the States' roles in representing and delivering health care and deciding the process for health care, and none of the issue which you have raised require that there be a Federal intermediary set up in the States who will decide whom you can buy health insurance from and how you

buy health insurance.

All the issues which you raise are very legitimate issues which can be resolved by correcting market mechanisms which presently are in place and which can be corrected, in my opinion, without un-

dermining the quality of care, which should be our goal.

In Mrs. de Vries' case especially, the concerns which she raises, which are extremely legitimate, which go to the question of availability of insurance for people, especially as people move into that gray area between hitting Medicare and not having Medicare. That issue can be resolved in large part by some form of modified community rating. And of course, the issue of preexisting condition which has been raised by Mrs. de Vries and by yourself, Mr. Pickering, in your diabetes situation, can also be addressed through insurance market reform by not allowing a preexisting condition to bar one from getting insurance coverage.

In the area of the early retiree not being able to get insurance, that really becomes a marketplace issue which I think the Federal

Government can have a role in, and can have a positive role in, as outlined by yourself, Mr. Pickering, in making sure that when you reach a contract with a major employer, that obviously you relied on in making your decision to go into early retirement, that that

contract is honored.

So I do feel that although your individual cases are extremely compelling, and they have to be addressed, and they should be addressed, the legislation necessary to address them does not have to be so broad as to sort of throw the baby out with the bath water, in other words, destroy the underlying quality of the system in an attempt to address individual problems which are systemic within the system, but are not necessarily dominating the quality issue.

So I would hope that as this committee goes forward in addressing concerns such as yours—and I do expect we will, because I think everybody on this committee wants to see a change in the way we deliver health care which will allow us to address the issue of preexisting condition, which will allow us to address the issue of community rating, which will allow us to address the issue of early retirees, which will allow us to address the issue of early retirees, which will allow us to address the issue of portability and the issue of malpractice and the issue of antitrust—all of those issues which I think there is agreement on can be moved on without having to go down this road which the President has suggested, which is a dramatic readjustment of the entire system in a manner which, although it may address your concerns, will probably also lead to greater concerns for you and for everyone else in bringing about a deterioration in quality.

So I think the concerns which you have raised here today are very legitimate and can be addressed by this committee and this Congress and should be addressed and will be addressed, but hopefully, in correcting the problems which you folks have, which need to be corrected, we will not end up creating a larger problem for

the society as a whole by deteriorating the entire system.

So that is a statement versus a question, but as a practical matter, I hope it addresses your concerns that you have raised in this committee

Thank you, Mr. Chairman.

Senator WOFFORD. One of the reasons I want to thank you for giving us your first-hand experiencing and focusing on several elements of the health care problem in the United States is my hope that if we do that, if we focus on the problems one by one and look at the elements and the potential solutions to the situations that you just presented, then when we add up what we have done, we will have comprehensive health insurance, private health insurance, guaranteed to everyone, whether they are working or retired, and at every point in their lives.

You are very welcome to comment on any part of the health proposals that you want to respond to. But I do not think any member of this committee wants in the end to have the health care plan live up to the description that Senator Gregg just gave, and I think we will come to the common ground by looking at specific elements

such as the elements that you have just put before us.

A common denominator for me of the three stories is that you have all experienced a certain kind of gambling—gambling with the most vital thing to all of us, which is life, liberty, and the pur-

suit of happiness. Life, liberty, and the pursuit of happiness depend on your ability to get health care when you need it. And each of you has had to deal with—as Elizabeth was saying she gambled and lost—but each of you gambled as to whether the fine print would cover you, or which plan would be best, and whether your spouse would be working and be able to cover you or not, and whether your employer would continue your benefits if you retired. And I guess out of your stories today, I am particularly going to take as a motto, as a watchword as we go forward, to somehow end this gambling that leaves you in this kind of situation. And if you go to an unemployment office today, you will see that gambling going on right there, with seven people sitting in a row who have lost their jobs. Maybe two of them have health insurance because they have a spouse who is covered by an employer, and five do not. So if we can find a way to end gambling in this field, we will have done something very important in these months.

Mr. Pickering?

Mr. PICKERING. I appreciated what Senator Gregg said. I would just say that I think the health problem is very, very complex. I do not think it is an easy thing to resolve. And certainly, I and the people I am representing would like this committee to give serious consideration to your amendment, Senator Wofford, with respect to 1268. It may well only be an interim step, but we think it merits serious consideration by the committee.

Senator WOFFORD. Among other things, it would see that while litigation is going on, the plans be kept in place rather than termi-

nated for maybe interminable litigation.

Mr. PICKERING. Right.

Senator WOFFORD. Senator Simon has joined us.

Senator SIMON. I thank you, and I apologize for arriving late.

Mr. Pickering, I want to tell you that your Senator has been sensitizing all of us to health care, and we appreciate that a great deal.

Mr. PICKERING. You will notice that I lived in Minnesota at one time. I think you have a Senator from that State who is pretty active in this area as well.

Senator SIMON. Yes, you are right.

Mrs. de Vries, I noticed at the end of your statement, you said you took a gamble and you lost. You said the bill from the first hos-

pital was \$22,469, and from the second, \$7,926.

In Mrs. Fitzwilliams statement, she said, "I had always heard that we have the best health care system in the world." And that is probably true for those who can afford it. But from your perspective, things look a little different right now.

I assume you are not a person of wealth as I read your statement. How are you going to pay that bill? That is \$30,000 alto-

gether.

Mrs. de Vries. Well, one hospital has approved my application for free care, God bless them; the other is still considering my application. Since I am now unemployed, I have no income at all other than my unemployment.

But I would have to say that the quality of the health care I received was not compromised by the fact that I had no insurance. Everyone was wonderful to me. And now that I cannot pay them,

I feel guilty, because what can they do—give me back my heart at-

tack? It is too late for them.

Senator SIMON. Well, it is to their credit that they gave you the quality care. But the reality is when the one hospital absorbs that kind of cost, under our system, what they do is they just shift the cost to someone else.

Mrs. de Vries. Precisely.

Senator SIMON. So clearly, our system has to be changed, and we have to make sure that everyone is covered, that there are not people who fall through the cracks as you have. And you mentioned your health insurance going up to \$400 a month. I know of a woman in Rolling Meadows, a suburban community in Chicago, whose health bill—because she had a health problem, cancer, from which the doctors said she had completely recovered—her health bill went up to \$1,400 a month, and she obviously could not afford it.

We thank you very much, and I thank you, Mr. Chairman, for

holding the hearing on this important subject.

Senator WOFFORD. And when the hospital shifts those hospital bill costs to others, it shifts it to Unisys, for example, and makes Unisys' health care plans so costly that Unisys then terminates its benefits or substantially reduces its benefits to Mr. Pickering, which is the point that we are all in this together in some way.

My wife was truly scared that if I lost this job in 1991, her preexisting condition of about 8 years would make insurance so costly or keep us from having it, that we would very soon be selling our home. I do not think that was the main reason she worked hard,

but she was truly scared.

And Georgia Fitzwilliams, I think you have a preexisting condition that would make it difficult for you if you lose the gamble.

Mrs. FITZWILLIAMS. Yes. In 1992, I was diagnosed with breast cancer. I am doing fine, and I do not expect that I am going to have to deal with it again—I hope not—but if I did, I would probably do as well as I am because early detection and all the things that are happening for women along this line is going to help, but without

health care, I will not beat it, and there is another battle.

What I would also like to say is that I am uninsurable, and if I do not have the job I have, I will not have insurance. The thing that occurred to me, though, is that my husband upon retiring, even if we could afford to buy the insurance for him, they are not going to cover me. So again, I have lost this bout altogether. And there are many women just like myself—and we should not be dying of breast cancer. I think that has been made pretty clear already, that there is enough technology now that women's lives could be saved, and we could save a lot of medical expenses. But we need to have the coverage in order to prevent that from happening.

Senator WOFFORD. Do I understand that your husband has to re-

tire at age 57?

Mrs. FITZWILLIAMS. Well, yes. What it is is the amount of years of service on the police department, and then they determine when your exit time is. Since the U.S. Supreme Court has struck down mandatory retirement, what the retirement program has done instead is said that, fine, if you want to work after age 58 or what-

ever that number is, we will start reducing your pension accordingly, so that it would be foolish to work beyond the time that they have set for retirement—and after 36 years as a police officer, I

think it is probably a good idea that he retire.

So you are kind of punished if you stay on the job to continue health insurance because eventually, then, when we have to live on that pension—the pension starts out at about 60 percent of his salary when we retire, which is fine, I guess; it is just that you do not get raises on that, and if health care increases, we are not

going to be able to afford it.

Senator WOFFORD. Your experience in the 55- to-64-year-old bracket also seems to me to underscore the problem of community rating. I hope the "modified community rating" that Senator Gregg talked about ends the discrimination against people who are in your age bracket. At just the moment when it is most difficult for you as early retirees to pay under the present rating system, your premiums go through the roof.

Mrs. FITZWILLIAMS. That is right.

Senator WOFFORD. True community rating that spreads the risk over the whole pool of age as well as large population, it seems to me, is the way for us to go. I hope Senator Gregg meant that in his modified community rating.

Any other questions, Senator Jeffords?

Senator JEFFORDS. Just one. Did I hear you right that your hus-

band's benefits would decrease if he retired later?

Mrs. FITZWILLIAMS. Yes. If he chooses to work beyond the time that he is eligible for the regular retirement program, if he is at 60 percent, that percentage would be reduced over the years, depending on how long he would work. And I do not know exactly how significantly that is going to affect us, but it seems like kind of a back door way of mandatory retirement.

Senator JEFFORDS. It is; it is age discrimination in a way, in an

interesting fashion. I had not heard that one being used.

Mrs. FITZWILLIAMS. Yes. They get pretty creative, I guess. Senator JEFFORDS. Yes, right.

Senator Wofford. Well, I hope on our side, we will get creative in these next 6 months in this committee and in other committees as we look at the elements of the problem, and you have helped us very much do that this afternoon. We thank all of you.

Our second panel consists of Joseph Perkins, William Bywater,

Mel Bass, Anna Rappaport, and Sylvester Schieber.

Leading off this second panel will be Joseph Perkins, who is a member of the board of the American Association of Retired Persons, and he is from Danvers, MA.

The second witness is a long-time advocate for working men and women, William Bywater, president of the International Union of Electronic, Electrical, Salaried, Machine and Furniture Workers.

Mel Bass is the director of health and benefit policy for the American Automobile Manufacturers Association. He comes to us not only in this capacity, but also as a spokesman for the Pre-Medicare Health Security Coalition.

Anna Rappaport is a fellow of the Society of Actuaries and a

managing director of William M. Mercer, Incorporated.

And last on this panel will be Sylvester Schieber, vice president of The Wyatt Company.

We appreciate your coming and helping us work together on how

we solve the problem.

Joseph Perkins?

STATEMENTS OF JOSEPH PERKINS, DANVERS, MA, MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS; WILLIAM H. BYWATER, PRESIDENT, INTERNATIONAL UNION OF ELECTRONIC, ELECTRICAL, SALARIED, MACHINE AND FURNITURE WORKERS, AFL-CIO, WASHINGTON, DC; MEL BASS, DIRECTOR, HEALTH AND BENEFIT POLICY, AMERICAN AUTOMOBILE MANUFACTURERS ASSOCIATION, WASHINGTON, DC; ANNA M. RAPPAPORT, MANAGING DIRECTOR, WILLIAM M. MERCER, INC., CHICAGO, IL; AND SYLVESTER J. SCHIEBER, VICE PRESIDENT, THE WYATT COMPANY RESEARCH AND INFORMATION CENTER, WASHINGTON, DC

Mr. PERKINS. Thank you, Mr. Chairman.

I am a member of the board of directors of AARP, and I am very definitely glad to be here to testify today. My written testimony discusses in detail the vulnerability of 50- to 64-year-olds and the reforms AARP believes are critical for this group to achieve health security. I would like to focus my oral remarks on a few points.

Older workers often face substantial barriers to working. Thirty-eight percent of 55- to 64-year-olds are not working. Many of the so-called "early retirees" have been laid off from their jobs or are looking, usually unsuccessfully, for a new job. They often face hiring discrimination, due partly to the perception that they are less productive, and the reality, admittedly, that they typically have higher health care costs. Many are forced to quit work due to health reasons.

Also among this 55- to 64-year-old nonworking group are women, who have spent years in the home raising children and who find themselves, widowed, divorced, or without a husband, or with a husband who is now eligible for Medicare, and for that reason has retired.

Only 35 percent of nonworking 55- to 64-year-olds have coverage through their or their spouses' current or former employers. The picture is even more bleak for women and minorities, who are less likely to have retiree health benefits. And those with coverage today could see it slip away tomorrow, as employers cut back on benefits or eliminate coverage entirely. And we certainly saw perfect examples of that in the first panel.

As a result, about 20 percent of nonworking 55- to 64-year-olds are uninsured. Another 10 percent must purchase coverage on their own. We know what that costs and have been told that already

today.

This vulnerable group faces three serious problems that health care reform must address. First, they face preexisting conditions, exclusions, and waiting periods that may deny them coverage at all. AARP strongly supports requiring insurance to take all comers regardless of health status and prohibiting waiting periods.

We are pleased that the debate in Congress has moved rapidly in this direction and encourage you to enact the insurance reform provisions along the lines of the President's plan in that respect.

Second, this group faces premiums that are much too high because they are not community-rated or offered as part of a group rate. AARP strongly supports pure community rating, that is, charging all individuals or families in an area the same premium for the same benefits package, regardless of age, gender, or health status. It is the way we used to be in this company back when insurance companies were insurance, believed in insurance, before they started cherry-picking the healthiest groups.

We strongly encourage Congress to rejected proposals that allow insurance companies to discriminate against older Americans by varying premiums based on age. Charging older persons higher premiums because of their age is similar to charging younger women higher premiums because they might have babies. There is no place in a reformed health care system for either of these dis-

criminatory practices.

Some have suggested that insurers should be allowed to age-rate premiums as a way to make higher income groups pay their share. AARP has long been an advocate of progressive financing in the health care system, but using age as a proxy for income is mis-

guided and is not supported by the facts.

Most of the so-called early retirees have low or moderate incomes. Of the 8 million nonworkes between 55 and 64, 34 percent have incomes less than 150 percent of poverty, and 55 percent of them have income levels less than 250 percent of the poverty level. They are not, as a lot of people believe, a high income group.

If Congress wants financing for health care to be based in part on income, then it should do so directly for everyone. Age rating

premiums will not achieve that goal.

A third and very important point is that this group does not have a sponsor to help pay the premium and not nearly enough income alone to pay for coverage even if the premiums are community-rated. And I again think of our previous three panelists, who very definitely gambled and gave up coverage because of the expense.

There is general agreement in this country that health insurance is simply much too expensive for individuals to afford. That is why many businesses pay for coverage today and why an employer mandate is so important to universal coverage; that is also why Medicare was enacted and why it continues to be such a popular program.

If we are to continue the employer-based system of health coverage, then nonworking 55- to 64-year-olds will need the same kinds of protections that workers and Medicare beneficiaries will

have under a reformed health care system.

We are pleased that the President's early retiree proposal would provide health security to a very large number of this vulnerable age group. It is important to keep in mind that those who would benefit most from the proposal, though, are those who currently have no health coverage at all. Particular attention should be given to low and moderate income individuals in this age group. AARP strongly supports the President's proposed Federal subsidies for nonworkers with incomes up to 250 percent of the poverty level.

I want to thank you for having us here, and I await any questions that might come our way.

Senator WOFFORD. Thank you for abbreviating your very inter-

esting testimony that all of us have to read and study.

[The prepared statement of Mr. Perkins may be found in the appendix.

Senator Wofford. Bill Bywater?

Mr. BYWATER. Good afternoon, Mr. Chairman and members of the committee. My name is Bill Bywater, and I am president of the International Union of Electronic Workers.

On behalf of the 150,000 working members and the tens of thousands of IUE retirees, I appreciate this opportunity to express the

views of the IUE on the growing retiree health care crisis.

Let me State that despite what others may say, we do have a

health care crisis.

Senator Wofford, with your permission, I would like to submit my written statement for the record and now summarize the major points.

Senator WOFFORD. Thank you.

Mr. BYWATER. The IUE notes with great alarm the recent decisions of many companies to shift health care costs they had previously borne to retirees. We feel this has been prompted by several factors, mostly the exploding costs of medical care and the failure up until now of the Federal Government to enact meaningful health care reform. Over the past 2 decades, as U.S. manufacturing declined, the IUE has tried to negotiate protections for workers forced into early retirement because of plan shutdowns. Health care benefits for these workers, who are usually between the ages of 55 and 65, are particularly critical, as they tragically find that they are too old to find new employment, yet too young to qualify for Medicare.

For the IUE, this issue was brought home in the case of the Unisys Corporation, where retired workers, including some 6,000 IUE retirees who had worked for Unisys' predecessor, the Sperry Corporation, had been threatened with the loss of their company-

paid health insurance coverage.

I worked for Sperry in Long Island City, NY for 17 years. As a local union officer and then as chairman of the IUE-Sperry Conference Board, I know personally that the IUE fought long and hard to negotiate health insurance coverage for Sperry workers

when they retired.

I want to add something to that. I was the chief negotiator in all the negotiations with the Sperry Corporation back in those years. When we negotiated a package—let us assume it was 50 percent that we were going for in a package—we would say, okay, we will take 10 cents or 7 cents or 3 cents, whatever it might be, and apply it toward insurance. So in other words, we were paying for it in lieu of a wage increase, and that is what we did. Then, that increase that was given to us, the union workers, also went to the unorganized, and I feel the same sympathy for the unorganized as I did for the organized workers, because they deserve the same benefits. So I am just saying that we paid for that. I want you to understand—it is not a question that the company gave it to us out of the goodness of their hearts; it was something we took out of our

package. I think that is important for you to understand.

While the Unisys decision to completely terminate retiree health benefits has forced the IUE to initiate divisive and costly litigation over this issue. However, a legal victory for the IUE would not protect the health care security of the majority of workers who do not have the benefit of union representation.

We believe that the Congress must act to ensure the retirement security of American workers, both union and nonunion. In our view, this tragedy cries out for immediate action and a long-term

solution.

The IUE believes Congress should reform ERISA to 1) recognize retiree health insurance coverage as a vested right protected by law; 2) give unions, often the only effective organized group supporting retirees, standing to sue under ERISA to protect the Federal rights of their former members. In the interim, Congress should at least take action to stop companies from terminating benefits while retirees are in the course of litigation.

We note that Senator Wofford has introduced such legislation, S. 1268. The IUE strongly supports Senator Wofford's bill and urges

the Senate to act promptly and favorably toward it.

Nevertheless, this problem needs to be addressed as part of comprehensive health care reform, particularly for the sake of the vast majority of workers, and the IUE insists that retirees age 55 to 64 and those workers who have lost their jobs because of plant closing and corporate restructuring be included in an overall program to guarantee every American health security.

The Health Security Act proposed by President Clinton addresses the problems faced by the pre-Medicare population by including a provision under which the Government pays the employer share of health coverage for the nonworking, pre-Medicare population in

order to protect these vulnerable individuals.

Unless this critical provision is adopted with respect to retiree health care, as well as coverage for the active work force, significant retrenchment and job loss in key manufacturing industries in the United States will continue. I do not want to see the industrial base of the United States eroded to any further extent than it has been already. That would be a danger for the economy of our coun-

try.

I believe the pre-Medicare provision in the Clinton health security plan will play an important role in restoring the competitiveness and productivity of many important sectors of the American economy. This will not only preserve existing jobs; it will also provide the basis for renewed economic growth and labor mobility that can generate new jobs in the future. It must be recognized that U.S. corporations that still provide retiree health benefits are often hurt competitively. Global competitors do not pay directly for retiree health care. Some critics of this provision have generated considerable confusion as to its true cost.

The budgetary impact of this important provision in the President's bill is estimated by the Office of Management and Budget at \$13.4 billion through the year 2000. This cost is more than offset by the following revenue raisers which total \$17.2 billion over the

same time period.

First, for calendar years 1998 to 2000, employers will pay an as-

sessment that raises \$11.4 billion.

Second, retirees in this group with high incomes will have to pay a tax to recapture the subsidy they receive. This tax provision raises \$0.2 billion.

Third, the savings to Federal employee health programs that will result from shifting early retiree health care costs into this new program as estimated by OMB at \$5.6 billion.

The net result over the budget period is revenue in excess of \$3.8 billion, which is used to help pay for other provisions in the President's bill.

Mr. Chairman, this provision enjoys a broad range of support from labor unions, companies, senior citizen organizations, local and State governments, and I would like to include for the record

a partial list of these organizations.

Mr. Chairman, of the other proposals before this committee, only Senator Wellstone's single-payer bill can be said to provide protection to early retirees to the level the Health Security Act does. All

of the other alternatives fall far short.

Some alternative plans call for the creation of purchasing cooperatives, but they leave the purchasing of health insurance voluntary or create an individual mandate. The Breaux bill taxes workers who receive health plans similar to what the IUE obtains for our members. We find such taxes on working and middle class Americans' health care benefits unacceptable.

The IUE stands ready to work with the committee as the Senate

moves forward to enact comprehensive reform.

We want to thank you for this opportunity to present our views, and Senator, I want to thank you especially for coming to the rally on the side of the retirees who are having their benefits taken away from them by Unisys. I know you went out of your way that day to be at that rally, and I must say our people greatly appreciated what you did.

Thank you.

Senator WOFFORD. We appreciate your being on our call today. [The prepared statement of Mr. Bywater may be found in the appendix.

Senator WOFFORD, Mel Bass?

Mr. Bass. Mr. Chairman, I appreciate your invitation to testify on this hearing on health care for the pre-Medicare retiree population. I am appearing today for the American Automobile Manufacturers Association which represents Chrysler, Ford, and General Motors.

These companies spent nearly \$6 billion in 1992 on health costs. Reserves for future retiree health liability amount to an additional \$3 billion. Together, all three companies provide comprehensive health coverage for 2.8 million people—one out of every 90 Americans.

AAMA's member companies strongly support comprehensive health reform that provides universal coverage financed in an equitable manner. Achieving universal coverage through our employerbased health insurance system will require a new allocation of responsibilities between Government, employers and employees. The allocation of responsibilities set forth in the administration's

Health Security Act whereby employers cover their active work force, and the Federal Government assists those no longer employed, would provide an equitable system for financing universal coverage. It would also markedly improve the competitiveness of firms which have traditionally provided health coverage to their

workers, retirees, and dependents.

Our current voluntary health insurance system puts mature, responsible firms with higher retiree health costs in an untenable position. They are confronted by a very unpleasant dilemma. As fewer and fewer firms provide health coverage for early retirees, should those firms that do provide such coverage continue to do so, thus becoming weaker and weaker competitors; or should they drop such coverage in order to become competitive with firms that do not have similar costs, thereby leaving their former workers uninsured?

This dilemma exists because competing firms have vast different health costs. The disadvantaged firms are those that have survived for many years and have been responsible in providing comprehensive health benefits to their current work force and former employees. A competitive example occurs to those firms with low health costs, either because have younger work forces or because they do

not provide any coverage to current or former workers.

According to the Government Accounting Office, only 4 percent of firms provide health benefits to early retirees; or, put another way, in 1988 only 44 percent of early retirees received health coverage from their former employers. Studies indicate these percent-

ages are strengthened each year.

Absent some remedial measure such as that contained in the administration proposal, market forces will eventually force almost all employers to eliminate early retiree coverage. This will leave a vulnerable segment of the population—those aged 55 to 64 with no current employer and higher health costs—with no assistance in

obtaining coverage other than the low-income subsidies.

We need to look realistically at the alternatives available. We can ignore this problem, leaving fewer and fewer early retirees covered by their former employers. We can mandate that all former employers provide coverage, but gaining wide acceptance of an employer mandate just to cover active workers will be hard enough. Or we can mandate that employers currently providing this coverage continue to do so. But this would be patently unfair because it would lock in the cost advantage currently enjoyed by firms that do not provide this coverage.

All firms should share in the burden of providing coverage to their active workers and nonworking dependents. Primary responsibility for providing basic coverage for those no longer part of the work force who are at a vulnerable age, 55 to 64, should be assumed by society at large. This levels the playing field between firms and eliminates unfair competitive advantages based on health care costs. It is also consistent with the health financing ap-

proaches used by our international trading partners.

Employers who advocate this approach are often accused of trying to dump their costs onto others. America's car companies have been paying inflated costs for many years due to cost-shifting from the uninsured, low reimbursement rates by Government programs,

and coverage provided to working spouses who do not receive coverage from their own employers. What they are actually saying is: "We are willing to pay our fair share, but we should not have to

pay more.

When the health care obligations of mature manufacturing firms were originally assumed, health costs were much lower and represented a smaller expense relative to wages, profits and other costs. It is important to recall the factors which have changed in the last few decades for American auto manufacturers: 1) health care costs have increased each year by two to three times the rate of inflation; 2) demographic changes have resulted in older work forces and a higher proportion of retirees to active workers; 3) cost-shifting has grown in magnitude. A study by Lewin/VHI indicates that due to cost-shifting from a variety of sources, manufacturing firms pay 28 percent higher health costs than they would otherwise. 4) Due to the pressures of global competition, companies have done substantial downsizing, resulting in large numbers of early retirees.

And fifth, the automobile market has shifted from one of domestic competitors only to one with foreign competitors and transplants. The transplants—that is, foreign firms with U.S. production facilities—have young work forces and no retirees. Foreign firms are based in countries with tax-financed health systems. As a result, these two types of firms enjoy a competitive cost advantage of \$500 to \$600 per vehicle based on lower health care costs.

These factors continue to magnify the health cost burden of the American automakers. Health costs are now the largest component of domestically-produced vehicles, amounting to \$1,100 per vehicle, greater than the cost of the next most expensive component, which

is steel.

Mr. Chairman, let me clear up a common misconception. The pre-Medicare retiree provision in the administration's bill would not shift all costs for early retiree coverage to the Federal Government. The Government would pay for 80 percent of the premium cost of the basic benefit package. Any supplemental benefits now provided by employers, such as dental and vision, as well as lower cost-sharing by employees, would continue to be paid by the employer who did provide such coverage. In addition, the savings to employers through the year 2000 would be substantially offset by an assessment on employers of 50 percent of either 1) the average cost of providing health benefits to early retirees during the years 1991 through 1993, indexed for medical price inflation-note that that is all the health care costs, not based on the 80 percent factor as is the Federal provision of the employer's share—or 2) the savings employers realize in the current year as a result of the Federal contribution—whichever is greater.

Mr. Chairman, Federal coverage of the employer share for the nonworking pre-Medicare population is a necessary component of any system to provide truly universal coverage. It will make coverage a reality for a vulnerable demographic group which is slipping between the cracks in our current voluntary system. Those former workers, who helped provide strength to the country for decades, should continue to have access to high-quality care as part of a national solution. Such a national solution will also improve

the competitive posture of firms with disproportionately high retiree costs.

Thank you, Mr. Chairman.

Senator WOFFORD. Thank you very much.

Anna Rappaport?

Ms. RAPPAPORT. Thank you, Senator Wofford.

I am pleased to have the opportunity to be here. I am a benefits consultant with William M. Mercer. I work on retiree health issues, primarily with employer-sponsored plans and with retirement benefits, but unlike the prior speaker, I do not represent my clients or employer and speak from my personal perspective in working with

this for many years.

I recognize the problems that the witnesses here have brought today, but I find a lot of commonality in those problems with the problems faced by other Americans who do not have coverage. I think it is important that those problems be solved, but I do not think it is necessary that there be a special program targeted at early retirees, particularly if we have reform, and I think most reform proposals would include several elements that would go a long way toward serving early retiree problems.

Those elements are that for people who do not have jobs or do not have employer coverage even if they do have jobs, that we would have purchasing cooperatives and not have preexisting condition limitations, so they would have a way to buy coverage through pools; we would have community rating; and we would have support for lower-income individuals through some kind of

subsidies.

I believe that these elements would solve the primary issues facing early retirees, and there is no need for a special entitlement program, no need to provide a greater subsidy to this group than to anyone else in a comparable situation.

I would also point out that among this group, there are both higher and lower-income individuals, and I think it is reasonable

that they might be treated comparably.

Like some of the earlier speakers, I am just going to touch on a couple of highlights of my written testimony. The four problems that I see are: access to coverage, which the purchasing pools could solve; cost of coverage. With community rating in fact, the early retiree group, if it were community rating with no age rating, would be getting approximately a 60 percent subsidy already because their underlying costs are higher based on age, and that would go a long way to solving the cost problems for most of them. Additionally, if there is support for lower income individuals, they would get subsidies above the 60 percent. The 80 percent of the premium subsidy that is called for in the President's bill, if you go back and think about the fact that that is layered on top of community rating, that is really a more than 90 percent subsidy of premiums for those people.

The purchasing cooperatives without preexisting conditions would solve the problem of preexisting. And there is a great problem of uncertainty, and if we had programs for people without coverage through their jobs, for people without jobs, that would solve

that issue.

So I see the problems as access, cost, preexisting condition limitations and uncertainty. I feel they should be solved. Like Senator Gregg, I do not think they require all of the things that are required in the President's proposal to solve them. And I do hope that they can be solved for all Americans, regardless of whether they are eligible for early retirement or not.

I would just like to make a couple of other points to highlight my written testimony and then hope that you will study the more

lengthy testimony in detail.

One of the concerns that I have had with the President's proposal is that it seems to me that there is some disparity in the way different groups are treated. And I have provided three examples of questions to be asked in terms of why should one set of people be treated versus another. Why should a person over age 55 not currently working, with 40 quarters of coverage for Social Security, be subsidized, whereas a nonworking individual at a younger age, maybe 54, might also have 40 quarters or coverage or not, but why should that person not be subsidized? What is the parity there?

Why should somebody eligible for Medicare get lesser coverage and maybe pay higher premiums than a retiree over 55? If Medicare continues to cover disabled people, why should a seriously disabled person eligible for Medicare get less coverage than a less dis-

abled person not eligible for Medicare?

All of these issues seem to create anomalies. I hope that a solu-

tion can be found that does not have those types of anomalies.

The last point that I would like to make in summary of that is that I feel it is really important that when we think about these issues, we think about them in the broader context of retirement policy, and we think about early retirees both in terms of retirement policy and health policy. I feel that there are many issues facing whether Americans will have the resources to retire—will we have enough money, what do we have to save, what do we have to do. I have been very concerned about retiree health benefits for many years. I have written extensively and participated in a lot of dialogues on this, and I certainly appreciate the importance of this issue, but like all other retirement security issues, I think it is important that it not be dealt with in a vacuum and that employers have the chance to deal with the issue also in a way that they can deal with retiree health adequately.

The proposal that I have made is that I have said that if you have reform that has the elements I have mentioned—the purchasing pools or cooperatives, community rating, and support for lower income—just treat early retirees like other people not working—I think it goes a way to solving the major problems, does not create an entitlement, and it leaves employers free to deal with their re-

tirement income policy issues in a much more rational way.

Thank you.

Senator WOFFORD. Thank you. Your Senator from Illinois wanted to make sure you got a proper Illinois welcome.

Senator SIMON. Yes. I welcome an Illinois witness.

Ms. RAPPAPORT. Thank you.

[The prepared statement of Ms. Rappaport may be found in the appendix.]

Senator Wofford. Sylvester Schieber?

Mr. Schieber. Thank you, Mr. Chairman.

I am Sylvester Schieber, the director of the Research and Information Center at The Wyatt Company. I appreciate the invitation to testify today, addressing the issues of early retiree health benefits in the context of President Clinton's health reform proposal.

The comments that I am presenting today and the more detailed comments in my prepared testimony are based on some national modelling work that we have been doing on health reform for the Business Council on National Health Policy. We have recently published a report evaluating broad aspects of the Clinton proposal and would be happy to make that available to the committee members if they are so interested.

The Business Council is a group of large firms working together with us to understand the ramifications of health reform for various sectors of the economy and for various segments of the popu-

lation.

We believe the early retiree proposal is largely misunderstood by many of the people who have not carefully evaluated it. Today, approximately 3.9 million people are receiving early retirement health benefits through employer-sponsored health benefit programs. On a group basis, the per capita cost of these programs this year will run somewhere around \$3,340 per person by our estimate. In other words, the total cost of benefits provided through these programs in 1994 will be somewhere around \$13 billion.

The employer share of that cost this year will be around \$10.4

billion, or roughly 80 percent of the total.

Under the Clinton reform proposal, there would be significant savings for employers. Many people believe that they would come simply from the Government's assumption of the 80 percent of the premium that the proposal includes. Indeed, there are a variety of other elements of the proposal that would cause significant savings.

As Anna just pointed out, for example, there would be significant savings from community rating. We estimate that under the reform proposal, looking at the comprehensive package of benefits offered to the whole population, that average premiums would drop from \$3,340 per person for this group down to a level of \$1,947. In other words, there would be a savings of approximately 42 percent of the

total cost here just on the community rating alone.

In addition, many early retirees continue to work in what I characterize as "shadow" careers. They go off and get temporary employment, jobs that will last 5 to 10 years beyond the point of their early retirement. Additionally, many of them have spouses who are employed for some time during their early retirement period. Both of these latter groups would be treated as people who would be covered under employer-sponsored benefit programs because they would be workers, and the Clinton proposal includes a mandate that employers provide health insurance coverage to most of the working people in the country.

In addition, some would receive subsidies as low-income individuals. Finally, the Government would assume 80 percent of the re-

sidual premiums for retirees between the ages of 55 and 64.

If you turn to Table 1 on page 6 in my prepared testimony, you can see our estimate of what the overall cost of providing the bene-

fits to current beneficiaries of early retirement benefits would be

under President Clinton's proposal.

First of all, plans for active employees—these are people who have either gone back to work themselves, or whose spouses work—would pick up about \$3.7 billion of the bill. The employers, left with the residual 20 percent that the President proposes, would pay about \$1.9 billion per year. Government subsidies would run about \$600 million. And the Government share, the 80 percent share, would only be \$1.1 billion.

Now, the employers who are currently providing benefits would definitely receive a substantial benefit from this proposal. We said earlier that this year their costs would run about \$10.4 billion. If the plan were implemented this year, their costs would drop to \$1.9

billion.

One of the issues that has not been widely discussed is that the issue goes well beyond current retirees receiving retiree health benefits, however. In Table 2, which is on page 7 of the testimony, we

look at the broader set of issues.

Currently, there are 3.9 million people receiving benefits. They would have approximately 300,000 dependents who would be entitled to benefits under the President's proposal. In addition to that, there are 3.2 million people between the ages of 55 and 64 today in the United States who are not working who are not covered by an employer-sponsored retiree health benefit program. They would also be eligible for benefits, and they have another 400,000 dependents who would also qualify.

Finally, in the last line in Table 2 in the prepared testimony, we show an estimate that there would be 400,000 new retirees who would retire from their current jobs because of the proposal. In the prepared testimony, I say that this estimate is not based on any empirical evidence. It is an estimate that has been published by the administration. The reason it is not based on empirical evidence is that the economists who have been looking at retirement

issues in recent years simply have not focused on this issue.

There are currently about 5.7 million workers in the United States between the ages of 55 and 64 who are participating in a pension plan or a tax-qualified savings plan. The reason that many of them have not retired is that they would not be eligible for a retiree health benefit if they were to leave their current job and take their retirement benefits, or if they were to qualify for a retiree health benefit, they would have to pay most of the premium, and these premiums are very significant, as we heard the first panel

mentioning.

Some of these people would face very different cost constraints under the Clinton reform proposal than they currently face. Currently, if they were to retire and pay for their own benefits, if they were a single individual, they would be paying a premium of at least \$3,500 a year; if they were buying a single plan, it could be as much as twice that to provide themselves with health insurance coverage. If they have a spouse who is roughly the same age as they are, that would double the cost of retiree health benefits again.

Under the Clinton proposal, they would only be responsible for paying 20 percent of the community-rated premium, which would

amount to about \$30 a month. So many of these people would go from facing a premium cost in the current world of \$300 to \$600, maybe even \$900 or more than \$1,000 a month, down to a premium of about \$30 a month. Many of the people who are currently eligible to retire and continue to work would retire under the Clinton proposal.

It is not clear to me that the 400,000 estimate is not a somewhat

conservative estimate.

Moving on to Table 3 on page 9 of the testimony, we summarize the overall cost of the Clinton proposal, including all of these additional retirees, including the 400,000 new retirees, and we still end up with the Federal Government in terms of the retiree element of the proposal only spending \$2.2 billion. So that in terms of a cost figure, this is a relatively moderate amount of the overall cost of

the proposal in its larger context.

I understand that there is currently discussion of dropping the early retiree proposal from the package altogether, although it is not clear to me what dropping the early retiree proposal might mean. Does it mean community rating? Community rating would cover 42 percent of the current cost. So if you have continued community rating, the large employers would still be alleviated of at least that much of the cost. Does it mean eliminating the employer mandate for people in "shadow" careers or retirees married to workers? That covers about 28 percent of the current cost. And why would you not mandate employers who hire older workers to provide coverage if you are going to mandate that they provide coverage to younger workers?

Does it mean eliminating the subsidies for low-income people simply because they have been covered by a retiree health benefit program in the past? That seems to be an arbitrary reason not to

provide them subsidies.

If the larger policy considerations mean that you keep community rating, employer mandates, and Government subsidies for low-income individuals, the residual cost for employers currently providing early retiree benefits would be about \$3 billion, even if you eliminated the 80-20 split between the Government and employers compared to the \$10.6 billion they are currently paying. So it would still be a very significant reduction in their cost.

You could levy a special tax to get back some of those savings, but if you did not implement the 80-20 split, it would appear to be a tax to punish the employers who in the past have offered retiree benefits, which puts it into the category of what I categorize as "No

good deed goes unpunished."

Alternatively, you could fundamentally disassemble other aspects of the proposal—the community rating, the employer mandates and so forth—but this would be the policy equivalent of the tail wagging the dog of public policy.

Thank you very much.

[The prepared statement of Mr. Schieber may be found in the appendix.]

Senator WOFFORD. I thank all five of you very much.

Let me first ask a question about community rating, pure community rating, modified community rating. Am I hearing right that all of you including Anna Rappaport mean by community rating

the end of the discrimination against the old? Some modified community rating proposals in plans before us would permit the differential to remain two-to-one.

Mr. Schieber. If you look at utilization of health services across the population, older groups of people use more services than younger people. The pure community rating principles would have

everyone paying the same premium.

If you look at this group of 8.2 million people that we think would be covered by the President's proposal, the community rating there would be we said it would drop their premiums by 42 percent. But someone has to pay the cost. The other side of the coin, if you will, is that younger people—and under the Clinton proposal, it would fall largely on workers—workers, their employers and their dependents would somehow have to pay these premiums.

The total cost of those premiums being redistributed to the rest of the population, the working population and their dependents, would raise their annual premiums by a per capita amount of

about \$65 a year.

Now, we talk about discrimination and discriminatory pricing. Some people might argue that if you go to a pure rating system, you are going to have younger people, who oftentimes are not financially well-off, paying premiums for older people. I think that is why some people suggest we should go to a modified rating system where maybe you would split the population into three groups or two groups and have the older people pay something closer to the share of the total costs that they are going to be generating.

Senator WOFFORD. Could other members of the panel give me

their judgment on what should be done in this matter?

Senator JEFFORDS. May I interject one question?

Senator WOFFORD. Yes.

Senator JEFFORDS. However, the community rating does not change the Medicare population as being borne entirely by the tax-payers; right?

Mr. Schieber. That is correct. Senator Jeffords. Thank you.

Ms. RAPPAPORT. I would just like to point out—and I generally agree with Syl—community rating does not reduce the cost in total. It just allocates the cost differently. And the question you have is if your broad social policy says that everybody should pay the same dollar per head, that is a form of community rating. If everybody should pay the same dollar, based on their age but not on their health condition, that is a form of community rating. And discrimination is really in the eye of the beholder and is something that is a value judgment.

So what community rating is is a form of cost-shifting from the present system. It shifts the cost to the population broadly, depending on how far you go with it within the framework that since older people are more expensive, you say they cannot afford that higher cost, and you are just reallocating it to the younger, and you are

not taking the cost away from the economy.

With regard to the Medicare issue and community rating, if you say Medicare would be a separate program, and we will community-rate among those not eligible for Medicare, then you are allocating the cost in that way, and that is another arbitrary decision.

Essentially, these are all social policy decisions that are based on

what you believe is the appropriate policy.

Senator WOFFORD. I am inviting your response to what you believe should be the appropriate policy, your value judgments on this.

Senator Simon?

Senator SIMON. If my colleague would yield, as I understand your testimony, Ms. Rappaport, you are simply saying that we should

not set up a separate category here; is that correct?

Ms. RAPPAPORT. I believe that early retirees should not be set up as a separate category, that the appropriate judgment is that there are a number of people who are not working and that it is appropriate to subsidize the poor, but that it is appropriate to treat early retirees with the rest of the not working population and, based on their income levels, they would either be entitled to those subsidies or not.

I would also say I question—it was not part of the subject here—but I question why Medicare should be a separate program, and if we are going to have a national program, why everybody shouldn't

be in the same program with the same benefits.

Senator SIMON. I think a political judgment has been made that

we are going to keep Medicare separate.

Senator JEFFORDS. Well, let me pursue that, though. What we are doing now is we are—or Congress is cost-shifting the Medicare population back onto the others as we just keep cutting the reimbursements; so the reimbursements get lower than the costs, and that part of the Medicare population is being cost-shifted now back to the rest of the universe; right?

Ms. RAPPAPORT. Absolutely. Mr. Schieber. That is correct.

Senator JEFFORDS. So it is not that we are not cost-shifting.

Mr. Bass. All of this cost-shifting is causing a disintegration in certain areas such as the one we are focusing on in this hearing, that is, for early retirees.

Senator JEFFORDS. Yes.

Ms. RAPPAPORT. But in terms of Senator Wofford's question, I do not think it is appropriate for the early retirees to be treated on a separate basis. I would put them together.

On the community rating, I do not have a strong feeling about whether we should have age-rating or not, but I think that is something that also there is a broader mandate that says we are going

in the direction of community rating without age-rating.

Mr. PERKINS. You know, this is nothing new to go community-rated. Large companies, large employers have people working from age 17 to age 65 and older, and in my company, over age 70. Every-body is charged the same premium rate. I understand there are some companies that are looking at age-rating now. So this is not a unique concept, and it is a level playing field, and it is what true insurance is. So I wonder why there is so much comment on this because of the fact that it is basically the way that most people have been paying their premiums in the workplace since there has been health coverage.

Senator Wofford. Bill Bywater?

Mr. BYWATER. I want to comment on Senator Wofford's proposal. It is important certainly to the people whom I represent, and to the people who are not represented by any union.

If a company, for example, negotiates with you, and they come to an agreement that is binding, and later on the company says, no, that was not our understanding, and they try to renege, they

may wind up in court like we have on Unisys.

The fact is, though, that there are also many contracts made between unorganized people and the management that are not in writing, but it is something that the company has said, "This is what we are going to do." Or they will send them a letter like we got—unorganized workers got letters from the company saying, "We are going to give you a guarantee. You are going to have this for your lifetime if you retire." The individual then takes that, like the gentleman over here did. He worked for that company, and he was a damn good employee, obviously, did a lot for the company, made personal sacrifices, and everything else. Then, the company changes hands and they look at him like he is a number; he does not mean anything anymore. There is no feeling of, well, this fellow made some sacrifices, and he deserves something-no. Unless you have a contract, they do not recognize it. They are in their litigation now, the unorganized group, and we are, too. I expect we are going to win something because the judge we went up against suggested that we get together and see if we could come to an agreement. And it looks like we may come to an agreement now and work something out in the Unisys thing for the organized. But I want to see the unorganized treated the same.

So what you are looking at is a problem that is here now. We cannot wait for something that may never be worked out in terms of health care. We hope it will happen this year, but suppose it does not? Right now, we have a problem. Here is a company, for example, that is bragging about how much money they made last year. They did a great job, and I give them credit—fine for all the stockholders that were involved. But what about the people that made the money for them? That is what it comes down to. It is a question of fairness, and we cannot wait. We cannot wait for something to come along maybe 5 years from now. Some of them will

be dead. They need the help now.

Therefore your bill that you are proposing is urgent, and that is why we want to see it passed now. That is why we feel that way. Senator WOFFORD. Thank you. And the "now" involves the plan

Senator WOFFORD. Thank you. And the "now" involves the plan now being terminated, the benefits being reduced while the litigation goes on for a long time.

Mr. BYWATER. That is right. Senator WOFFORD. Mr. Bass?

Mr. Bass. Senator Wofford, I will make two comments about the discussion on community rating. I think one way that people look at community rating is to say right now, if we sort of level the amount of premiums across all ages and risk categories, then you have younger—the perception is, at least in this year—you have younger, healthier workers—"subsidizing" is the word—older, less healthy workers.

But another way to look at it is over the whole lifetime of a person. If you have community rating during your life, you are guar-

anteed that you are going to pay reasonable rates throughout your lifetime and that, sure, you may be paying more early, but later on, you are going to be paying less. And that is another perspective on it.

Of course, from the standpoint of companies, going to community rating is very important because those firms that are fortunate enough to survive and exist for many years through no fault of their own end up with older work forces and more retirees. And under our current experience-rated system, they have higher health care costs and so forth, so this would be important to at least leveling things somewhat between employers so that their health care costs are not extremely disadvantageous to one group or advantageous to another, oftentimes competitors.

Senator WOFFORD. You said "somewhat." Would you want to elaborate on that in response to the suggestion that community rating would do a lot? To what extent do you feel that the community rating and the low-income subsidies and other elements deal

with the problem versus the special retiree formula?

Mr. BASS. I do not have percentages for you, but there is no doubt that community rating is a help; it is a piece of the entire structure under the administration's Health Security Act. That is helpful. The increased low-income subsidies to eliminate so much cost-shifting from public programs or from the uninsured to those who are paying the bills is important. But this third piece, the help

for the pre-Medicare retiree population is important, too.

As I tried to say in my testimony, I do not think it is fair to pull this provision out, that is, just the program for the pre-Medicare population, and look at it in isolation. We have to look at the entire package, and we are really talking now about a reallocation of these responsibilities and where are the gaps and where do we need to fill, and what role should the Federal Government play, what role should employers pay. And I think it is appropriate, as I said before, to say employers, if we mandate and require that you make a contribution to coverage for your active work force and their nonworking dependents, then the Federal Government will help other parts of the population.

So I think it is important to look at any of these proposals in the

whole and not pull one piece aside and examine it in isolation.

Senator WOFFORD. Does the panel want to comment on the proposition I put at the beginning, that unless we do something, the kind of problems that we heard from our first three witnesses are going to grow, that more and more companies will be forced to reduce, diminish, terminate the benefits in retirement that they had offered?

Mr. Bass. That is what the evidence continues to show.

Mr. Schieber. The situations that employers face is that the overwhelming majority of employers in this country face are private, for profitmaking entities. Health costs have been one of their most rapidly rising costs in recent years. If you go to the economics literature, and you look at the whole issue of who pays for these benefits, I think Mr. Bywater was very clear in his discussion earlier, that at least the unions sit down, and they understand that they are separating out some cents per hour to cover their health

costs. But I think most economists conclude that for active workers,

the health benefit is part of the wage bill.

The issue with retirees becomes much more confusing because the retirees are no longer there on a day-to-day basis, contributing to productivity. And that puts a terrible pressure on the employer because in an economic sense, that benefit over time becomes a gratuity, and in an extremely competitive environment, that is one of the issues that they are forced to look at.

We deal with employers every day. They do not gracefully or routinely or maliciously walk up to the decision of terminating these benefits. It is a very difficult decision for them. And if you look at the evidence, if you look at what has happened over the last 10 years, these benefits are being curtailed on an increasing basis. And I think if you expect that somehow automatically, they are going to start expanding again, I think that is a pipe dream. I think the trend is definitely going to continue to be negative.

Senator WOFFORD. Ms. Rappaport?

Ms. RAPPAPORT. I agree with Syl and would add this. He talked about the for-profit sector. If you think about State and local government, if you think about the not-for-profit sector, just as business is faced with competitive pressures, all of these organizations are faced with a lot of pressure on their sources of revenue, their tax bases. They are having to choose between spending more on health care or more on employment, spending less on education or less on something else. So that everybody is under financial pressure.

We also see many of our clients having to make choices between things like jobs and benefits. So while employers are not taking lightly any of these discussions, and they want to take care of their retirees and their employees, there are frequently major pressures in that regard, and we have seen many businesses have financial problems that are not good for the people in our communities.

So yes, I would agree with that, and I think it is part of a com-

plex issue relating to employment. Senator WOFFORD, Thank you.

Senator Jeffords?

Senator JEFFORDS. Thank you, Mr. Chairman.

I just want to pursue the social policy aspects here. Ms. Rappaport, I agree with you that we should take into consideration income security and the benefits that you are referring to, and at the same time, we look at what the social policy ought to be.

Incidentally, Mr. Bywater, I would ask you to take a look at my S. 1047, called the Medicorps Act, which most of the unions and

businesses like very much.

But let me just go to the social policy aspect. If we had a seamless system, which I guess is a simple way of saying community rating, over the whole age spectrum, and if we were to take the position that we ought to take all of the costs that are presently being borne by the private sector and distribute them equally by some progressive policy—these figures were verified by the Joint Tax you could reduce the cost to employers to 6 percent of payroll. If you also wrapped in the adjusted gross income of individuals, and then you had a flat tax, in a sense, which conservatives seem to like, of 6 percent, you can raise all the money which is presently

being spent by the private sector in health care.

And when you do that method, you get rid of all of the problems that we have been talking about. You do not have a retiree problem because everyone would pay 6 percent of their reduced income. For a business which happened to have guaranteed health care and is going to have a windfall because they will no longer have to pay those high costs, you could require them to pick up the 6 percent. And you can go right on down through. Your businesses whose average costs are about 12 percent would be more competitive.

But my main purpose for looking at that option is to say there is no sense being old and healthy if you are old and poor. If you are living in a hole, and you are healthy, you really are not enjoying life. The next crisis we are going to be facing in this Nation is how we are going to support all of the older people with the high health care costs going up, up, and up, and a percentage of GNP reaching 20 or more percent, how in the world are you going to have enough to pay the Social Security benefits and so on in the

future.

So I realize I am a little bit far out beyond what people are focusing on now, but I would like to take a look at what you can do if you decide to make those kinds of leaps and say let us undo all the

cost-shifting, let us build one seamless system.

An additional benefit is that you can freeze the Federal cost and get your budget right under control because you can freeze the Medicare and the Medicaid and keep transferring that to the States, and let the seamless system bear those costs, and you can get your budget under control in 2 or 3 years.

I would just throw that out.

Mr. Bass. Senator Jeffords, I might just say—and I know you all are well aware of this—what you are focusing on there is really the way the system is financed and a more equitable way to finance it.

Senator JEFFORDS. Right.

Mr. Bass. But totally separate and apart from that is the whole delivery system and the current incentives and so forth that have

to do with bringing those total costs down.

Senator JEFFORDS. Absolutely. This presumes a capitated payment system which you could distribute on a capitated basis. I notice the Wharton Business School in Pennsylvania has come out with a system which would take my financing and make it into a total health care plan, and we are working with them on that. They reverse the incentives on providers so that you make money by saving money instead of making money by increasing the amount of care you deliver.

Mr. Bass. I think that is what the administration is trying to do with their accountable health plans, with the risk-adjusted pre-

miums.

Senator JEFFORDS. Yes. Mine is a simple way, and that is why I am on their plan. I just said, you know, all you have got to do, guys, is get rid of all this financing business and adopt my financing. And it is kind of ironic, but they said, yes, but if we do that, we will get labelled with a \$300 billion tax.

And of course, what happened was CBO came out and said that

is a tax-you can call it a "premium" but it is a tax.

Senator Wofford. In 1941, when England was hanging by a transatlantic lifeline, wondering whether America would do the needful to stop the Nazi onslaught, Winston Churchill said, "I do believe that the American people, in their good common sense, will in the end do the right thing, after they have considered every other alternative." And Senator Jeffords is a cosponsor of the Health Security Act, but he also has one of the most thoughtful, far-reaching proposals, and he has had confidence that in the end his proposals in several respects will be given very serious consideration. And those who are not familiar with his bill should review it, because as we look at elements and stop worrying about which bill is up and which bill is down, it is very important for us to draw on all of the best ideas that have been put forward as we look at problem by problem.

Senator Simon?

Senator SIMON. Mr. Schieber mentioned the possibility that if this coverage is there, as many as 400,000 people would retire. I would like to ask Mr. Bywater, would that be a good thing for the Nation?

Mr. BYWATER. Well, I will tell you, one of the problems we have is competition internationally. And obviously, if the costs keep going up in the corporations, and they keep going overseas, or we lose our competitiveness to let us say France or someone else who is subsidizing all the time their various corporations, that becomes

a major problem.

Some in the labor movement will say we have got to reduce everything to a 35-hour work week. I like that, but the problem is that if we do that, that is going to hurt us competitively. That is not really the answer. If you stop all the overtime, that would certainly be helpful. But to just let people retire, I do not think the average person wants to retire. I think most people want to continue to work until they are around 60 or so; some would like to

retire a little bit earlier than 65, obviously.

But I do not think there is an easy answer to this thing. I think the answer, though, is that health care is a major problem to every corporation. For example, I deal with GE; I negotiate with GE primarily. What GE pays in premiums and what our costs came to out of that particular package has escalated because we are paying for those who have no health insurance whatsoever. We are paying for that. Everyone in this room knows that and certainly should understand. That keeps going up, and it creates more and more of a problem.

There are more strikes that unions have had across this Nation in the past half-dozen years over health care costs—not over other things, but over health care—because the company wants to shift the cost to the people, and the people say, "No, we are not going

to accept that; you have got to take care of that cost.'

Now, a strange thing has happened. Here we are, a union, and we have a company saying, "Hey, we are for a bill for health care." Now, why are they for it? Because of the problem they have selling automobiles that, for example, you go across the border in Canada,

and you can sell the car for a lot cheaper than you can here in the

United States because they are absorbing that.

So there are subsidies that are made all the time across the United States for various things. Even honey is subsidized. We have all kinds of subsidies for farmers, cattle ranchers, and everyone else.

So I am saying if there is going to be a subsidy, I think the subsidy certainly should be in the area where we really need work, and that is in the area of automobiles and various other parts that we have to develop here in the United States. To me, the industrial base is the most important thing, and if you are going to subsidize, you should subsidize that. That is the way I feel about it. So it is very important.

Do I want to see retirees? Sure, I want people to retire earlier. I do not think we can afford, though, to keep having people retire earlier because what happens then is it happens with many companies where you have more people retired than you have working. Now, what are you going to do then? How are you going to support that? What are you going to do? That is a major problem for us,

and that is unfortunately what is happening.

Senator SIMON. I thank you, and incidentally, I just saw a figure the other day that in 84 percent of the strike or potential strike situations now, health care is a major problem. I ended up 6 years ago mediating the Chicago Northwestern Railroad strike, which Ms. Rappaport may remember. We went into all kinds of details. Health care did not even come up. It was not an issue. Well, that is just not the situation today. When I talk to both sides at Caterpillar or wherever the dispute is now, it is a major issue.

Just one comment for Mr. Perkins. In your prepared statement, you mentioned long-term care. In the President's bill, which I am pleased to cosponsor, the nonresidential care is partially covered, but residential care is not covered. Clearly, as you look toward where we are headed, that is going to be a major problem. I would like to work with your organization as well as with the other senior organizations to see what kind of practical answer we can come up with, and I would like to prepare an amendment in that field. So I would just pass that along, and I would be eager to work with you on that.

Mr. PERKINS. Thank you. And of course you know our draft proposal very definitely included residential care as part of that com-

ponent, too.

By the way, can I mention something a little bit anecdotally on this question of whether there will be more early retirements as a result of pre-retirees having coverage. It has not been true in my company. I have been counseling early retirees for 20 years now, and it has always been a situation where our early retirees do get coverage at age 55, if they stay to 55. We find very little movement into retirement at the early retirement ages—55, 56, 57, 58—even when we have had early retirement incentives. There has been a tremendous amount of attrition.

So I really cannot question other than anecdotally, but I question whether there will really be the impact on early retirement to the

extent that some people think there would be.

Senator WOFFORD. Although there are clearly cases in major industries and in public employment sectors where reductions in force for one reason or another have been decided upon as necessary, and if we do not do something to deal with the early retirement question, the trade-off is that it is going to come in layoffs, and some people will be staying at work who would prefer early retirement, in order to keep their health care benefits. So that it seems to me a crucial part of this problem is what will happen if we do not do anything, and one of the things that will happen will be in many cases where early retirement would be good all around, for the young people and for the people who would like early retirement, without health care benefits possible for them, that cannot happen.

I have to say I am sorry that we have had a roll call vote a few minute ago, and I think I have about 7 minutes to get to the floor,

which is why my colleague have just departed.

I invite this very significant panel, like the first panel, if you wish to add anything to your prepared statements as final remarks, because I will not be able to hear them now, please do so,

and it will be made a part of the record.

This has been very valuable. It is just the beginning. We have got a long way to go on this and every other part, but we are going to also need to do it with speed so we can do it this year, in this Congress.

[The appendix follows.]

### APPENDIX

### PREPARED STATEMENT OF JOSEPH PERKINS

Good afternoon. I am Joseph Perkins, a member of the Board of Directors of the American Association of Retired Persons (AARP). Thank you for inviting me to testify on the health coverage problems of the 50-64 year-old population and for the opportunity to speak with the Committee on how the needs of this age group might best be addressed in health care reform legislation.

About half of AARP's members are under age 65 and not yet eligible for Medicare. Many in this group face substantial problems in getting and keeping health insurance and in paying for health care costs that are not covered. AARP hears from our quite vocal, younger members every day that they want and need comprehensive health care reform. We hear from workers laid off from their jobs and unable to ouy affordable health insurance because of their age. We hear from Medicare beneficiaries whose wives and husbands are not yet eligible for Medicare and must try to buy insurance on their own. We hear from mid-life women who, in order to care for parents with long-term care needs, quit their jobs or work part-time, and, as a consequence, lose their health insurance. Not surprisingly, 50-64 year-olds are more critical of the U.S. health care system than any other age group (see Chart 1). More than 40 percent of 50-64 year olds believe that the quality of their health coverage will decline in the future or that they will lose coverage entirely (see Chart 2).<sup>2</sup>

# AARP and Comprehensive Health Care Reform

AARP is committed to enactment of comprehensive health care reform in 1994. Reform must include:

- universal coverage so that every American can afford care and so that costs are not
  continuously shifted among providers, insurers, and businesses seeking to reduce their
  burden:
- a comprehensive defined benefits package for all Americans that includes <u>prescription</u> <u>drugs</u> and <u>long-term care</u>;
- strong <u>cost containment</u> measures in the public <u>and</u> private sectors that make health care costs more affordable for Americans; and
- <u>financing that is shared</u> fairly among government, businesses, and individuals so that
  universal coverage will not become an empty promise as families find health
  premiums increasingly unaffordable.

While AARP has not endorsed any specific health care reform plan, we believe the President's proposal is the best and most realistic blueprint to date for achieving these objectives. We will continue to work with members of Congress, on a bi-partisan basis, to help enact a bill that can achieve broad support.

### Profile of the 55-64 Year Old Population

While AARP membership begins at age 50 and there are many 50 year-olds with health coverage problems, most of the focus has been on the 55-64 year-old population. Of the 21.2 million Americans age 55 through 64 in 1992, only half of them work full time (see Chart 3).<sup>3</sup> Thirteen percent work part-time, and 38 percent (or 8 million Americans) are not working.

Who are these people who are not working, and why are they not working? Too often the simplistic and frequently inaccurate label "early retiree" is applied. Many of these so-called "early retirees" have been laid off from their jobs or are looking -- usually unsuccessfully -- for a new job. In fact, three-fourths of the unemployed in this age group are the result of job loss or layoff. It takes them 50 percent longer to find a job than any other age group, and, if they are over 60, they are only half as likely to get any job. Indeed, many simply leave the labor force or find part-time work. Despite the Age Discrimination in Employment Act, hiring discrimination against older persons is prevalent, partly due to the perception that they are less productive and the reality that they typically have higher health costs. In addition, many Americans in this age group must quit work due to health reasons. Amongst the 55-64 year-old non-workers are women who have spent years in the home raising children and who find themselves widowed, divorced, or with a husband now eligible for Medicare.

Most of the so-called "early retirees" have low or moderate incomes. Of the 8 million non-workers between 55 and 64, 34 percent have incomes less than 150 percent of the poverty threshold. Fifty-five percent (or 4.4 million individuals) have incomes less than 250 percent of the poverty threshold.

Of the entire 55-64 year-old population, 2.7 million were uninsured. And most troubling, about 60 percent of these uninsured have been without coverage for at least 5 years (see Chart 4).5

For working 55-64 year-olds who are uninsured or at risk of losing coverage, the President's proposal requiring all employers to contribute to the cost of coverage would go a long way toward addressing their health care needs. Since most Americans currently get their health coverage through their employer, this is not a revolutionary concept. The reasonable

concern that an employer mandate could lead to job loss in the short term must be balanced against the fact that our current health care system contributes to job loss and other serious work force problems. AARP believes that concerns about impact on small businesses ought to be remedied through careful phase-in of employer obligations, with subsidies and other mechanisms available during that phase-in to avoid economic peril for individual employers.

Of course, the millions of 55-64 year-olds who do not work or work only part-time are much more likely than their full-time working counterparts to be uninsured. Twenty-two percent of part-time workers in this age group were uninsured in 1992.<sup>6</sup> Of the 8 million 55-64 year-olds not working at all, 1.5 million or 19 percent were uninsured in 1992. Enacting an employer mandate for current workers will not solve the coverage problems of non-workers. Other solutions are obviously needed.

# Where Do Non-Working 55-64 Year Olds Get Their Health Coverage?

"Early retirees" are 16 times more likely to be insured if health coverage is available from a former employer than if it is not.<sup>7</sup> That's good news today for those who are fortunate enough to have retiree health benefits, but only about 35 percent of non-working 55-64 year olds have coverage through their or their spouse's current or former employers (see Chart 5).<sup>8</sup>

Moreover, only 29 percent of female retirees and only 26 percent of non-white retirees under age 65 received retiree health benefits from their employer. The General Accounting Office (GAO) estimates that 96 percent of America's businesses offer no health benefits to retirees.

Those with retiree health care coverage today could see it slip away as employers cut back on benefits or require retirees to pay higher premiums or copayments. Indeed, a recent Foster-Higgins study indicated that about half of all firms surveyed reported cutbacks or planned cutbacks. While retirees have often brought suit to protect their benefits, the courts have generally permitted employers to alter or eliminate coverage.

Those who do not have coverage from a former employer get coverage from four major sources<sup>10</sup>:

Medicare -- 1.1 million or 13.6 percent
 Medicaid -- 1.07 million or 13.4 percent
 CHAMPUS,VA -- 0.6 million or 7.4 percent
 Other private -- 0.9 million or 11.5 percent

This still leaves 19 percent of non-working 55-64 year olds without any health coverage at all.

More than 30 percent of non-working 55-64 year olds are either uninsured or must purchase coverage on their own. This vulnerable group faces three serious problems that health care reform must address:

- pre-existing condition exclusions and waiting periods that may deny them coverage at all;
- premiums that are much too high because they are not community-rated or offered as part of a group rate; and
- no "sponsor" to help pay the premium and not nearly enough income alone to pay for health premiums, even if they are community-rated.

### Out-of-Pocket Health Costs Are High

Not only do older persons typically pay higher premiums for their health coverage than younger groups, but they also have much higher out-of-pocket costs for deductibles, copayments, and services not covered. In 1987, 50-64 year olds spent 80 percent more out-of-pocket per person on cost sharing than did the 24-44 year old group (see Chart 6).<sup>11</sup> As a percentage of family income, the average 50-64 year old spent 2.3 times more in out-of-pocket costs than the average 24-44 year old. In 1994, average out-of-pocket costs for non-working 55-64 year olds were about \$1,200.<sup>12</sup> These estimates do not include the enormous cost of long-term care, for which very few Americans have coverage. Many 55-64 year olds bear the costs of their parents' care in nursing homes and community-based settings.

### Need for Eliminating Pre-Existing Conditions and Waiting Periods

As a result of poorer health status, 55-64 year-olds are more likely than their younger counterparts to have pre-existing conditions that discourage employers from hiring them and insurance companies from selling them coverage. AARP strongly supports requiring insurers to "take all comers" regardless of health status and prohibiting waiting periods before coverage begins. We are pleased that the debate in Congress has moved rapidly in this direction and encourage you to enact the insurance reform provisions along the lines of the President's plan. With universal coverage and a risk-adjustment mechanism that levels the playing field for health plans with higher cost enrollees, insurance companies will have no legitimate argument for denying coverage or setting waiting periods.

While pre-existing condition exclusions are a major barrier to coverage for some 55-64 year olds, a more important obstacle for a larger number of people in this age group is the high premiums they must pay.

### Need for Community Rating Without Age Adjustments

AARP strongly supports pure community rating -- that is, charging all individuals or families in an area the same premium for the same benefits package regardless of age, gender, or health status. It's the way we used to do business in this country before insurance companies started "cherry picking" the healthiest groups and avoiding the less healthy groups. Many who argue against community rating charge that it rewards those who behave irresponsibly -- e.g., smoking, drinking heavily, overeating, engaging in unprotected sex -- or otherwise add costs to the health care system. Yet, the way to attack these problems is directly through programs addressing alcoholism, tobacco use, poor diet, and lack of education -- not after the fact through insurance rating.

Moreover, the aging process should not be looked upon as a "problem behavior," even though it tends to increase health care costs. We strongly encourage Congress to reject proposals that allow insurance companies to discriminate against older Americans by varying premiums based on age. Charging older persons higher premiums because of their age is similar to charging younger women higher premiums because they might have babies. There's no place in a reformed health care system for either of these discriminatory practices.

Some have suggested that insurers should be allowed to age-rate premiums as a way to make higher-income groups pay their share. AARP has long been an advocate of progressive financing in the health care system. But using age as a proxy for income is misguided and is not supported by the facts. Allowing insurers to age rate would make non-working 55-64 year olds with low to moderate incomes pay substantially more for health coverage than younger individuals with higher incomes. If Congress wants financing for health care to be based in part on income then it should do so directly for everyone. Age-rating premiums will not achieve that goal.

Finally, if Congress allowed age-rating of premiums, then federal subsidies for older non-workers would have to be set at a much higher level than for younger populations so that the value of the subsidy would be consistent across all age groups.

# Need For A Sponsor and Subsidies To Help Pay for Premiums

Even with community rating, very few non-working 55-64 year-olds will be able to pay the entire health premium on their own. There is general agreement in this country that health insurance is simply much too expensive for individuals to afford. That is why many businesses pay for coverage today and why an employer mandate is so important to universal coverage. That is also why Medicare was enacted and why it continues as a very popular program today. If we are to continue the employer-based system of health coverage, then non-working 55-64 year-olds will need the same kinds of protections that workers and Medicare beneficiaries will have under a reformed health care system.

AARP is pleased that the President's "early retiree" proposal would provide health security to a very large number of this vulnerable age group. It is important to keep in mind that those who would benefit most from the proposal are those that currently have no health coverage at all. They include widows and former homemakers without retiree health benefits; men and women who suddenly find themselves unable to work, underemployed, or forced out of a job; and families counting the weeks and months until both husband and wife obtain Medicare eligibility at age 65.

Particular attention should be given to low and moderate income individuals in this age group. AARP strongly supports the President's proposed federal subsidies for non-workers with incomes up to 250% of the poverty level.

Insurance reform, community rating, and government subsidies are all needed to assure that vulnerable, non-working 55-64 year-olds can share in the promise of universal coverage.

As the Congress confronts the many difficult choices that must be made to reform our health care system, we urge you not to take the path of least resistance on those things that matter most to older Americans and their families. Particularly for the 50-64 year-old population, the status quo is the worst and most expensive option. And those proposals that fail to address the many health coverage problems of this population leave out a very vulnerable and vocal group. If universal coverage is the objective, and we believe it must be, Congress will need to make sure that so-called "early retirees" do not get lost in the debate.

AARP looks forward to working with this Committee to realize the goal of universal coverage and ensure that 50-64 year-olds obtain equitable treatment in comprehensive health care reform legislation.

DYG, Inc. "Health Care Reform: Where The Public Stands" for the American Association of Retired Persons Department of Federal Affairs, May 1993.

Sofaer, Shoshanna and Jean Johnson. "Health Insurance Access Among Near Elderly Americans." Draft Report to the American Association of Retired Persons' Public Policy Institute, February 1994.

<sup>&</sup>lt;sup>3</sup> U.S. Bureau of the Census, Current Population Survey (CPS), March 1993.

<sup>&</sup>lt;sup>4</sup> U.S. Census, CPS, March 1993.

<sup>5</sup> Sofaer.

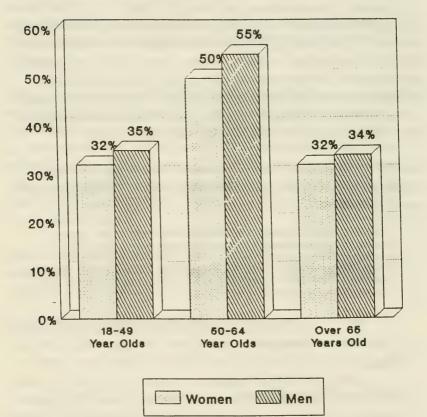
<sup>&</sup>lt;sup>6</sup> U.S. Census, CPS, March 1993.

<sup>7</sup> Sofaer.

U.S. Census, CPS, March 1993.

CHART 1

# Rating of The Current U.S. Health Care System as Poor -By Age and Gender-



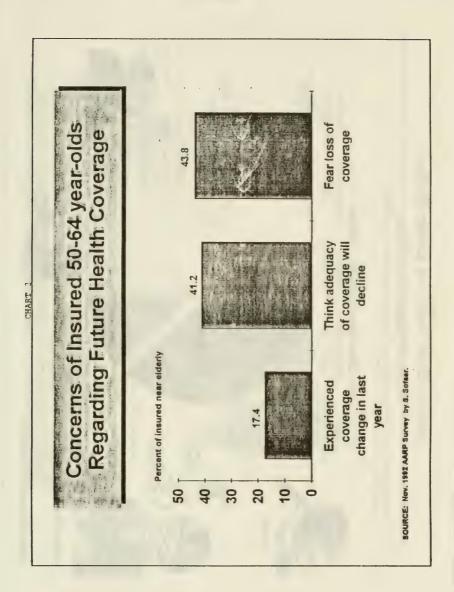
Poor: Rating of 3, 2 or 1 on 10 point scale

<sup>9</sup> U.S. Department of Labor, "Trends in Health Benefits," 1993.

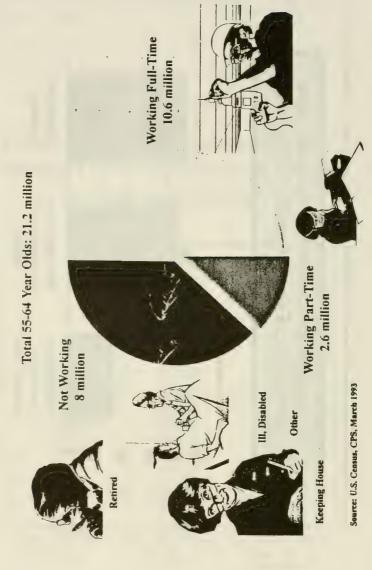
<sup>10</sup> U.S. Census, CPS, March 1993.

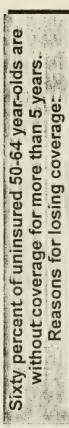
<sup>&</sup>lt;sup>11</sup> National Medical Expenditure Survey, 1987.

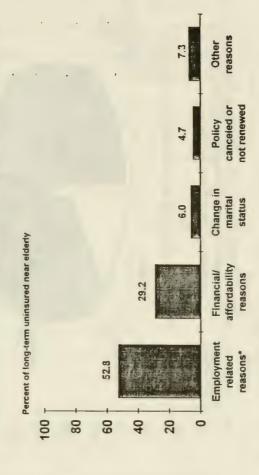
<sup>12</sup> Lewin-VHI estimates for the Commonwealth Fund, using 1987 NMES.



# Half of 55-64 Year Olds Either Do Not Work or Work Part-Time

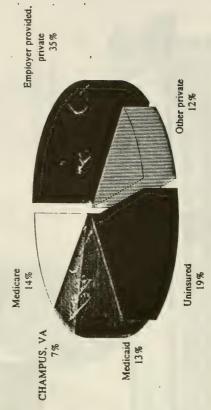


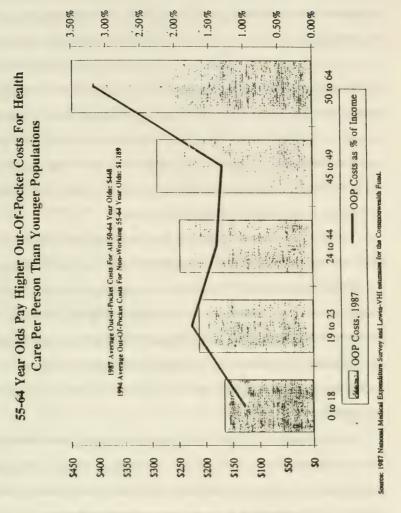




SOURCE: Nov. 1982 AARP Survey by S. Sofaer.
"Reasons include change in work status, retirement, and elimination of coverage-offer by employer.

Source of Health Coverage for Non-Working 55-64 Year Olds





PREPARED STATEMENT OF WILLIAM H. BYWATER

Good afternoon Mr. Chairman and Members of the Committee on Labor and Human Resources. My name is William H. Bywater, and I am the President of the International Union of Electronic, Electrical, Salaried, Machine and Furniture Workers (IUE), AFL-CIO. On behalf of the 150,000 working members, and the tens of thousands of IUE retirees, I appreciate this opportunity to express the views of the IUE on the growing retiree health care crisis. And let me state further that despite what others may say, we do have a health care crisis.

The IUE represents workers within a broad spectrum of manufacturing industries including electrical machinery, electronics, automobiles and parts, aircraft and aerospace, power-generation equipment, and furniture. Our members work for some of the largest corporations and federal government contractors in the United States, including General Electric, General Motors, North American Phillips, Rockwell International, Unisys, United Technologies, and Westinghouse, as well as a myriad of smaller companies. The collectively bargained-for health care benefits that these companies have agreed to provide to their retired workers are as varied as the businesses themselves. Equally varied are the situations and conditions our members find themselves later in life.

The IUE notes with growing alarm, the recent decisions of many companies to renege upon contractual agreements and shift health care costs to retirees. We feel this has been prompted by several factors, including the exploding costs of medical care, the failure (up until now) of the federal government to enact meaningful health care reform, recent changes in financial accounting standards, and a political environment where employers feel at liberty to attack their unionized employees and former workers through the reduction of negotiated economic benefits.

It is important to note that while unionized workers may have different legal rights and equitable claims against their former employers than do non-represented employees, the summary cancellation of retiree health coverage affects both union and non-union retirees alike. For union-represented retirees, however, employers' efforts to shed their retiree health care liability is particularly bitter in light of the trade-offs union negotiators have been forced to make in order to attain such benefits.

Since the 1930's, industrial unions have generally sought to negotiate the same health insurance protections for retired members as for active members.

And, over the past two decades, as U.S. manufacturing declined, the IUE, like other industrial unions, has negotiated such protections for workers forced into

early retirement because of plant shutdowns. Health care benefits for these workers, who are usually between the ages of 55 and 65, are particularly critical, as they tragically find they are too old to find new employment, yet too young to qualify for Medicare.

For years, our members relied upon common law and common decency to guarantee these negotiated protections. This guarantee remained clear after the passage of ERISA, until the mid 1980's when federal courts began to allow companies to shed their contractual commitments, giving a "green light" to this most reprehensible form of employer conduct. Today, the state of the federal law is, at best, uncertain, and too many employers, relying on this uncertainty, are trying to turn their back on retirees with the stroke of a pen.

For the IUE, this national disgrace is brought home in the case of the Unisys Corporation¹ where retired workers, including some 6,000 IUE retirees who had worked for Unisys¹ predecessor, the Sperry Corporation and its Remington-Rand, Sperry-Rand, Sperry-Univac and Sperry-Vickers Divisions, have been threatened with the loss of their company-paid health insurance coverage. I myself worked for the Ford Instrument Division of Sperry in Long Island, New York from 1941 through the 1950's. As a local union officer and then as Chairman of the IUE-Sperry Conference Board, I know personally that the IUE fought long and hard to negotiate health insurance coverage for Sperry workers when they retired.

While the Unisys decision to completely terminate retiree health care benefits has forced the IUE to initiate divisive and costly litigation over this issue. However, a legal victory for the IUE would not protect the health care of the majority of workers who do not have the benefit of union representation.

We believe that there is much the Congress can and must do to ensure the retirement security of America's workers. In our view, this tragedy cries out for immediate action and a long-term solution.

<sup>&</sup>lt;sup>1</sup>Unisys Corporation was created in 1986 as the result of the merger of the Burroughs Corporation of Michigan with the Sperry Corporation of New York

The IUE believes Congress should reform ERISA to:

- Recognize retiree health insurance coverage as a "vested right," protected by law;
- Give unions, often the only effective organized group supporting retirees, standing to sue under ERISA to protect the federal rights of their former members;
- Subject employers who intentionally violate retirees' contractual and ERISA rights to health insurance to exemplary damages.

In the interim, Congress should at least take action to stop companies from terminating benefits while retirees are in the course of litigation. We note that Senator Wofford has introduced such legislation, S.1268. The IUE strongly supports Senator Wofford's bill and urges the Senate to act promptly and favorably toward it.

Nevertheless, this problem needs to be addressed as part of comprehensive health care reform. The IUE insists that retirees ages 55 - 64, and those workers who have lost their jobs as a result of plant closings and corporate restructuring, be included in an overall program to guarantee every American health security.

The Health Security Act proposed by President Clinton addresses the problems faced by the "Fre-Medicare population" by including a provision under which the government pays the "employer share" of health coverage for the non-working Pre-Medicare Population in order to protect these vulnerable individuals. This is a critical provision needed to meet the goal of universal health coverage.

It will also increase labor mobility and productivity and improve the competitiveness of U.S. companies.

This provision is also consistent with a general principle of comprehensive health reform, namely, that there should be a level of playing field between all employers so companies are not forced to compete on the basis of health care costs. Unless this principle is adopted with respect to retiree health insurance

coverage, as well as coverage for the active workforce, significant retrenchment and job loss in key manufacturing industries in the U.S. will continue.

Many of the companies with large retiree health liabilities face declining market share in international markets, resulting in lower production and employment. This, in turn, can create a vicious cycle in which the workers are the victims. As these companies downsize, the ratio of retirees to active workers increases. Ironically, higher productivity in industries that have invested in modernization to increase competitiveness, has also had the perverse impact of increasing the ratio of retired to active workers.

Thus, in addition to assuring the security of health care benefits for the Pre-Medicare population no longer in the workforce, the Pre-Medicare provision in the Clinton health care plan will also play an introduction restoring the competitiveness of many important sectors of the American economy. This not only will preserve existing jobs; it also will provide the basis for renewed economic growth that can generate new jobs in the future. It must be recognized that U.S. corporations that still provide retiree health benefits are often hurt competitively. Global competitors do not pay directly for retiree health care; domestic competitors may have a younger work force or a much lower ratio of retirees to active workers, or a policy of no retiree health benefits. Over time, the reduced ability to compete inevitably results in even greater job loss.

Some critics of the this provision have generated considerable confusion as to its true cost. I would like to take this opportunity to clear up any misinformation the Committee may have. The budgetary impact of the provision in the President's bill to pay the 80 percent "employer" share of premiums for non-working individuals aged 55-64 is estimated by the Office of Management and Budget (OMB) at a cost of \$13.4 billion through the year 2000. This cost is more than offset by the following revenue raisers which total \$17.2 billion over the same time period:

- (1) For calendar years 1998-2000, employers will pay 50 percent of the greater of (a) the average cost of providing health benefits to this group during the years 1991-1993, indexed for medical price increases, or (2) the money employers will save in the current year by not having to pay for the health benefits for this group. This employer assessment raises \$11.4 billion.
- (2) Retirees in this group with high incomes will have to pay a tax to recapture the subsidy they receive. This tax provision saves \$0.2 billion.
- (3) The savings to federal employees health programs (both civilian and military) will that will result from shifting early retirees health care costs into this new program are estimated by OMB at \$5.6 billion.

The net result over the budget period is revenue in excess of costs of \$3.8 billion, which is used to help pay for other provisions in the President's bill.

A table which specifically outlines the costs and revenues associated with the Pre-Medicare provision is attached.

Mr. Chairman, federal coverage of the "employer" share for the non-working Pre-Medicare population is an important aspect of providing universal coverage. It will assure coverage for an important demographic group which has significant problems related to affordable health care coverage. The beneficiaries of this provision include the individuals who are uninsured or underinsured who will gain coverage, as well as the individuals now covered who will gain the security that they will not lose their existing coverage. The economy as a whole will also benefit through increased labor mobility and productivity and improved competitiveness of U.S. companies.

This provision enjoys a broad range of support from labor unions, companies, senior citizen organizations, and local and state governments.

Mr. Chairman, I would like to include, for the record, a partial list of those organizations.

Mr. Chairman, of the other proposals before this committee, only Senator Wellstone's Single Payer bill can be said to provide protection to early retirees to the level the Health Security Act does. All of the other alternatives fall far short.

Some of the alternative plans call for the creation of purchasing cooperatives, but they leave the purchasing of health insurance voluntary or create an individual mandate. Many of the plans, including the Breaux bill, will end up taxing workers who receive health plans similar to what the IUE obtains for our members. We find such taxes on working and middle class health care benefits unacceptable.

The IUE recognizes the compelling need for comprehensive health reform and for providing universal coverage to all Americans. We stand ready to work with the Committee as the Senate moves forward to enact comprehensive reform.

Thank you for this opportunity to present the IUE's view.

# PREPARED STATEMENT OF ANNA M. RAPPAPORT

My name is Anna M. Rappaport. I am a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries and serve as a Managing Director of William M. Mercer, Incorporated. I am a benefit consultant and have extensive experience in working with employer-sponsored plans to provide retiree health benefits and with retirement benefits overall. The testimony I am presenting today represents my personal perspectives and not that of William M. Mercer, my clients, or any organization.

### Summary

The Clinton Administration had made certain proposals with regard to health coverage for early retirees. I support an alternative. I believe that early retirees should be treated in the same way as other individuals without current employer coverage assuming compatible reform. This recommendation is based on reform which includes provision for purchasing pools for individuals without current employer coverage, community rating, and subsidies for lower-income individuals. In my testimony, I will show how such a program addresses the major issues and concerns facing both individuals and employers and that the Administration's proposal by going as far as it does creates an unwarranted additional entitlement program.

### **Current Situation**

The present situation with regard to the provision of health benefits for retirees in the United States can be separated into benefits for early retirees, and benefits for those over age 65 who have Medicare coverage. Retirees over age 65 can have spouses not yet eligible for Medicare. Today, I am focusing primarily on early retirees and spouses of Medicare-eligible retirees who are not eligible for Medicare themselves.

Many employers offer these retirees and family members continued coverage in their employer-sponsored medical plans. These arrangements range from programs where the employer pays 100% of the cost to arrangements where the individual pays 100% of the cost. Many other employers offer no coverage beyond what is required by COBRA.

In my article, "Clinton's Prescription for Health Benefits: What Are Some of the Issues and Challenges in the Debate?", published in the Winter 1993/1994 Benefits Law Journal, I discussed special issues related to retirees. A copy of that article is attached to my testimony.

The concerns with the current system from the perspective of the current and future retiree as reviewed in that article are summarized here:

- Many companies offer no coverage.
- Prior to Medicare eligibility, there is very limited access to coverage where there is no employer plan, and that coverage tends to be extremely expensive.
- Caps and/or increasing cost sharing may make coverage unaffordable for some even when offered by employers.
- People who leave before retirement age generally receive no retiree health benefits.
- Employers have generally reserved the right to change coverage, thus there is insecurity with regard to these benefits.
- There is no mandated funding or plan termination insurance.
- Long-term care is generally not covered.
- Some plans do not cover prescription drugs.

From the plan sponsor's point of view, there are also problems and issues for those who offer the coverage including the following:

- Level of current and projected costs.
- Unpredictability of future costs as well as other risks related to providing the coverage.
- Unpredictability of public policy as expressed both in legislation and litigation.
- Changing rules and a changing environment, making it very difficult to manage the benefits.

For plan sponsors who do not offer coverage, there is a different problem. Employees at early retirement ages may be unable to secure and/or afford coverage if they retire, so that the absence of coverage is an effective barrier to retirement. This can lead to problems for both employer and employee since neither is served well by an individual who wishes to retire being unable to because of lack of access to health care. Whether this is a federal concern depends on the general retirement policy. This issue should be addressed as part of a broader focus on retirement policy. Other retirement policy questions are raised later in the testimony.

We can summarize the issues as being related to access to coverage, cost of coverage and uncertainty about the future.

### Reform Proposals

The Administration's proposal calls for transferring the liability for early retirees to the Regional Alliances, and for subsidizing 80% of the cost for most early retirees. There are a number of other reform proposals, but they do not explicitly deal with this issue. The Administration's proposal also calls for asking employers who are currently sponsoring plans to repay the government for some of the cost reduction that results from this subsidy and the reduction in employer liability. It should be noted that under the Administration's proposal no other group gets the same type of subsidy.

The Administration's proposal seems illogical in that early retirees (defined as age 55 with ten years of Social Security credit) are treated better than any other group. An individual who chooses to leave prior to age 55 or is forced to leave as a result of downsizing and may not be able to find another job is in a far worse position with regard to this coverage (and often, very likely in total). At age 65, coverage drops when Medicare is effective. This raises several questions:

- Why should an individual over 55 not currently working with 40 quarters of coverage be subsidized when a nonworking individual at a younger age is not subsidized?
- Why should individuals eligible for Medicare get lesser coverage (and perhaps pay higher premiums) than some retirees over age 55?
- If Medicare continues to cover disabled persons, why should a seriously disabled person eligible for Medicare receive less coverage than a less disabled person not eligible for Medicare?

These questions are discussed in more detail in the article attached.

### An Alternative Proposal

I believe that an alternative will adequately address the concerns raised. This section of the testimony addresses that alternative and how it meets the current problems with early retiree coverage.

Embedded in several of the health care reform proposals are some common threads:

- Individuals who are not working (or do not have access to coverage through an
  employer plan) can purchase coverage through a purchasing cooperative
  (Regional Alliance in the Administration's proposal) without evidence of
  insurability or application of pre-existing condition limits (at least if coverage
  is continuous).
- Community rates should be used by the purchasing cooperative.
- Very low income individuals should be subsidized and some should have free coverage based on income.

If reform were adopted and these principles were embedded in the reform proposal, the problems related to early retirees as a group would disappear, and they could be treated the same way as any non-working individual. The key points with regard to such treatment are as follows:

- Access to coverage would no longer be an issue.
- The cost of coverage would be much less of an issue for early retirees because
  of the inherent subsidies already provided for by community rating. This is
  discussed below.
- Employers (assuming they continued to play a role in the system generally)
  could still offer coverage, but those who did not would not be faced with the
  choice of employees leaving without access to coverage or having to stay to
  maintain medical benefits.
- Some early retirees may be low income. They would be entitled to subsidies beyond those inherent in community rating on the same-basis as all other low income individuals without employer coverage.
- Such a proposal would introduce parity between early retirees and other nonworking individuals. To offer a special subsidy only to early retirees is equivalent to creating a new and uncalled for entitlement program.

I support this alternative as providing an adequate solution without unnecessary additional subsidies.

## Impact on Retirement Behavior and Benefit Programs of Clinton and Alternative Proposals

The Clinton proposal and the alternative proposal would remove access and uncertainty about health benefits as a barrier to retirement. Both, therefore, would encourage some people to retire early who might not have done so otherwise as a result of such a change. The Clinton proposal would facilitate early retirement for more people since it offers greater subsidies for early retirees. Some concerns have been raised that the proposal would make it more difficult for employers to retain good people, a goal of employers in sponsoring retirement plans. Government policy for the last decade has focused more on later retirement rather than early retirement, so that policymakers should consider whether they wish to encourage earlier retirement.

Employers have been struggling with retirement benefits and policy for the last few years. A stream of legislation and regulation have forced most of them to revise their benefit plans. At the same time, financial pressure, employer restructuring and downsizing have left many people out of work prior to retirement age, often involuntarily, or forced unwanted job changes and have forced employers to look at all spending including retirement spending. Increases in health care costs for active employees and retirees have tended to crowd out wage increases and other benefit spending. Employees have been retiring earlier while as a population we have been living longer.

Many employers have or will re-examine retirement income policy. (Nationally our policy is fragmented due to conflicting objectives of deficit control, employee protection and using tax policy as an income distribution device.) Retiree health has been a "problem" in dealing with benefit policies and retirement for some of the reasons cited above. If health care reform were enacted and if the alternative proposal were part of the reform program, then employers could look at retirement income policy with more freedom. They would be better able to consider:

- Substituting cash for medical benefits without concern about access to coverage and fear that retirees were vulnerable to being wiped out by medical costs.
- Total retirement income policy in light of the changing needs and demographics of the organization.
- If their philosophy were to offer medical benefits to their work force, they
  would have flexibility to do this after retirement also, and more freedom to
  tailor benefits to their need.

It should be noted that many individuals cannot afford to retire early (and some not at all). The alternative proposal does nothing to address that issue per se, but that is a broader issue, and it removes the problem of access to medical coverage as an additional problem.

## Cost of Coverage to Individuals Under Alternative Proposal

Currently, the cost of coverage for early retirees is very high for several reasons:

- Costs increase by age and coverage is expensive at older ages.
- Some early retirees are in poor health so that costs are often even higher for this group than for a broad group of those over age 55.
- For individual policies and employer plans with high contributions, costs are higher because individuals in poor health are more likely to try to buy coverage. (This is referred to as anti-selection.)

Under the alternative proposal, there are some broad subsidies spread over the entire population. Community rating and guaranteed insurability spread the cost of poorer health evenly over the population. Community rating could be applied on an age-rated basis, or without age rating. If it applied without age rating (as seems more likely), then there is already a subsidy based on spreading costs by age.

Using a broad community rate (non-age rated) for an early retiree group would be equivalent to a subsidy of about 60% of their cost for such a group. The premium they would be charged would be heavily subsidized through this process, and costs should be just as affordable for this group as any other group. (Note that the Clinton proposal for an 80% subsidy is actually a proposal for a more than 90% subsidy, since the 80% subsidy is applied to a community-rating premium which already has an approximately 60% subsidy built in for early retirees.)

The alternative proposal addresses the cost issue adequately without providing more subsidy to this group than any other group.

### Costs of Early Retiree Coverage

Employers who offer early retiree coverage find that it is very costly, often \$5,000 - \$8,000 average per person covered at ages 55-64, with substantial annual increases. Individual companies have very large liabilities for early retiree benefits. The Clinton Administration has had various cost estimates prepared for the cost of subsidizing early retirees. I have not confirmed or analyzed these estimates, but suggest great caution in looking at these costs. Employers have found many surprises, and the same could well be true in a public program.

Another point should be raised with regard to costs. Some businesses would benefit significantly by the Administration's proposal, whereas others would not benefit at all. The benefit to employers is very unevenly distributed by industry and company.

### Public Policy: Related Questions if Alternative Proposal is Adopted

If the alternative proposal is adopted, that still leaves open-related questions. Should public policy encourage employers to offer coverage to rettrees, discourage employers from offering such coverage, or provide no guidance? Currently policy tends to be ambivalent. The tax treatment of benefits is such that employers are encouraged to offer coverage, but other policies and regulatory instability strongly discourage employers from offering coverage. It is my opinion that if employer coverage is part of the health care system, then it is desirable to encourage employer coverage of retirees also. This raises another set of related questions: If coverage is be encouraged, should there be alternatives for funding which are similar to pension funding alternatives? Policy issues related to this matter should be considered in light of both health care policy and retirement income policy generally.

#### Conclusion

I appreciate the opportunity to share these comments with the Committee and encourage you to consider the alternative proposal for early retirees.

### PREPARED STATEMENT OF SYLVESTER J. SCHIEBER

Mr. Chairman, I am pleased to appear before you today to discuss the issues related to President Clinton's health reform proposal and how early retirees' health benefits would be financed if that proposal were enacted into law. I appear in my capacity as Director of The Wyatt Company's Research and Information Center.

The Wyatt Company is a consulting firm that helps employers deal with a wide variety of human resource and risk management issues, including the design and administration of their employee benefits programs.

The analysis that I will be presenting today is based on work that we have been doing for The Business Council on National Health Policy. The Business Council is comprised of a group of large U.S. employers that we have been working with over the past year to understand the issues related to health care reform. In particular, we have attempted to develop quantitative and qualitative analyses that will provide policy makers and business sponsors of health benefit programs a better understanding of the roles that employers and their workers might play under various reform alternatives.

The Business Council was organized to provide a critical review of various health reform alternatives. To date, it has not been an advocacy group, and I am not here today in an advocacy role. The sponsoring companies of the Business Council, drawn from the Fortune 500, make use of the research expertise of The Wyatt Company to evaluate and inform members and other interested parties about the implications of various health care reform proposals at both the national and individual firm level. In keeping with the overall charter of the Business Council, we have recently prepared and published an analysis of President Clinton's health reform proposal. One aspect of that report focused specifically on the President's proposal that would change the way early retiree health benefits are funded.

### Current Provision and Funding of Early Retiree Health Benefits by Employers

Tabulations of survey data developed by the Department of Labor suggest that at the beginning of this decade roughly 40 percent of workers in firms with 100 or more employees were covered by health insurance plans that would provide benefits to early retirees. Since late 1992, employers with retiree health benefit programs have been required to include estimates of the accruing cost of these programs on their annual income statements and estimates of the total accrued liabilities in the programs on their balance sheets. While employers must account

for the accounting costs of these programs, the ability to prefund retiree benefits during a worker's career are extremely limited by the Internal Revenue Code in comparison to cash retiree benefits paid through tax qualified plans.

Today there are approximately 3.9 million pre-65 retirees receiving health benefits through employer-sponsored plans. On an experience-rated basis,--that is, under current underwriting practices that adjust premiums for age, health status, etc.--we estimate that the cost of the benefits that will be provided under these plans will average \$3,340 per person during 1994. In other words, total health outlays under these plans will be approximately \$13.0 billion this year, of which roughly 80 percent will be directly financed by employer payments through the plans. Thus, the employers' outlays to provide early retiree benefits this year will cost them about \$10.4 billion.

The distribution of early retiree coverage and the cost of retiree health benefits is not randomly distributed across the various industrial sectors of our economy. Provision of early retiree health benefits tends to be concentrated among larger industries, especially manufacturing industries that have been unionized for years. This concentration of retiree health benefit obligations has led some policy analysts to worry that certain sectors of our economy might be unduly burdened by retiree health costs to the point that our overall competitiveness in a world economy is being harmed. To some extent, this concern has motivated the early retiree provisions in President Clinton's health reform proposal. Under that proposal, retired workers ages 55 to 64 would receive health care coverage through regional alliances and would pay only 20 percent of the total premium required to finance the coverage. Employers who are currently obligated to provide retiree health benefits would pay the retiree's 20 percent share of the premium for early retirees grandfathered as of October 1, 1993. Theoretically, the federal government would pay the remainder.

### Replacing Current Early Retiree Health Benefits Under the Clinton Proposal

On the surface, President Clinton's proposal that the government pay 80 percent of the premiums for early retiree health benefits seems quite

straightforward. In actuality, there are several elements of the total proposal that would affect retiree health costs and which render initial impressions wrong about who will pay the bill for this proposal.

For example, one important aspect of the President's proposal involves community rating to set the premiums for most people who would be covered under the regional alliances. These community rates would spread the cost of health services delivered under the plan evenly across all age groups. People between the ages of 55 and 64 would realize significant advantages by moving from experience rating to community rating. Our estimate is that the average community-rated premium to cover individuals in this age group under the President's plan would be \$1,947 this year if the proposal were fully implemented in 1994. Although the cost of delivering services to the individuals in this group would average \$3,340, the community-rated premium would require that the premiums paid by or for the group would only cover 58 percent of that cost. The other side of community rating, of course, is that other covered individuals would pay more for their services than they would under experience rating.

Using community premium rates that we estimate would be required to pay for the benefits provided by the Clinton package, the total premiums needed to cover current early retirees would be \$7.6 billion this year if the plan were currently implemented. Of this cost, between \$200 and \$300 million would be covered by some residual Medicaid benefits that would still be available under the reform proposal.

Another important consideration in evaluating costs under the President's proposal is that many early retirees still have working ties. Many early retirees have shadow careers that often last five to ten years after they leave their primary career jobs. Many others have a spouse who continues to work outside the home for some period beyond their own retirement. In both cases, the individual who is currently receiving an employer-sponsored retiree health benefit would be covered under employer-financed coverage for active employees that would be mandated by the Clinton reform proposal. Table 1 shows our estimate that active employee

plans would cover \$3.7 billion, or slightly over half, of the total premiums required to cover current early retiree health benefits recipients under the reform proposal.

Table 1 also shows that employer sponsored retiree health benefit plans would be left with a bill of \$1.9 billion under the President's plan. Comparing this to the \$10.4 billion that we estimate their current plans are costing, it is hardly surprising this proposal has some extremely strong advocates in the employer community. But the government's cost for these current beneficiaries of early-retiree health benefits would be quite modest in the overall context of the health reform proposal. Of the total estimated federal cost of \$1.7 billion, \$0.6 of it would be in the form of subsidies for low-income individuals. In other words, the government's cost of "paying 80 percent of the premiums" of current early-retiree

Table 1

Cost of Health Benefits Under Clinton Reform for Individuals Currently Receiving An Early Retiree Health Benefit

Plans for active employees	\$3.7 billion
Employers' retiree plans	1.9 billion
Government subsidies	
Low-income retirees	0.6 billion
Retiree proposal	1.1 billion
Total	\$7.3 billion

Source: The Wyatt Company, *The Economics of Health Reform*, Report prepared for The Business Council on National Health Policy (January, 1994), p. 13.

health beneficiaries would be only \$1.1 billion, relatively insignificant in that it covers the government's 80 percent obligation to replace a benefit that currently costs \$13.0 billion. The problem is, this is not the end of the story.

## Total Financing of Early Retiree Health Benefits Under the Clinton Proposal

The actual number of early retirees who would be affected by the Clinton proposal is significantly larger than the number of individuals currently receiving

employer-sponsored early retiree health benefits. Our estimates of the additional people who would be covered under the proposal are shown in Table 2. First, we estimate that the current 3.9 million beneficiaries of employer-sponsored retiree health plans have 300,000 dependents who are not now eligible for coverage under these plans but who would be covered under the Clinton health reform proposal. In addition there are 3.2 million people aged 55 to 64 today who are no longer working and do not now receive health insurance through an employer-

Table 2

Covered Retiree Lives Under Clinton Health Reform

Current retirees with benefits	3.9 million
Newly covered dependents	0.3 million
Current retirees without benefits	3.2 million
Associated dependents	0.4 million
New retirees	0.4 million
Potential eligible retirees and dependents	8.2 million
Source: The Wyatt Company. The	

Source: The Wyatt Company, *The Economics of Health Reform*, Report prepared for The Business Council on National Health Policy (January, 1994), p. 14

sponsored program who would be covered under Clinton's reform plan. This group has 400,000 dependents who would also be eligible for coverage.

The last category of recipients in Table 2 is an estimate of the individuals who would retire because of this proposal. This estimate comes from the Clinton Administration; it is not based on any empirical estimates of retirement behavior in response to availability of retiree health benefits of the sort being offered in this proposal--i.e., it is a guess.

We estimate that today there are 5.7 million working people between the ages of 55 and 64 who are covered by a tax-qualified retirement plan. Many of these individuals continue to work today because their employers either do not

sponsor retiree health benefits, or would require that beneficiaries of such programs pay most or all of the premiums. On average, these workers would face health premiums of \$3,500 or more per year for single coverage if they were to retire today. If they have a spouse about the same age as they are, the cost of coverage would be double that amount. Under the Clinton health reform proposal, these same individuals would be eligible for health benefits if they retired and paid 20 percent of the community rated premium. As stated earlier, we estimate that premium would be \$1,947 if the program was in effect this year.

Many people are locked into their jobs today because they face health premiums of \$300 to \$600 per month or higher, if they can even get health insurance. These people would now be guaranteed health insurance coverage at a monthly price between \$30 and \$65 depending on whether they were buying single coverage or coverage that includes their spouse. The costs these people currently face would change significantly under President Clinton's proposal. Undoubtedly, many of these people would be freed from the job lock that now constrains them.

Using the Administration's estimate of 400,000 additional retirements because of the incentives in the proposal, we estimate that a total of 8.2 million people would be eligible for early retiree benefits. The cost estimates for covering these early retirees and the distribution of those costs are shown in Table 3. The reason that the cost for active employee plans rises from those shown in Table 1 is that some of the early retirees not currently covered by a retiree health benefit plan are married to someone who is currently working and not receiving health benefits from his or her employer. In these cases, the retirees would be covered under the spouses' active employer plan. The consumer outlays are 20 percent of the total premium that early retirees would pay to provide their coverage in cases where their prior employers did not provide coverage. Bottom line, while the estimate of the government's total cost of providing the early retiree health benefit is up to \$7.2 billion when all early retirees are included in the picture, still only \$2.2 billion

of that is directly attributable to the government's takeover of "80 percent of the premiums."

Table 3
Cost of Health Benefits Under Clinton Reform for Everyone Receiving An Early Retiree Health Benefit

Plans for active employees	\$4.4 billion
Employers' retiree plans	1.9 billion
Consumer outlays	1.9 billion
Government subsidies	
Low-income retirees Retiree proposal	5.0 billion 2.2 billion
Total	\$15.4 billion
Total	noillid 4.61¢

Source: The Wyatt Company, *The Economics of Health Reform*, Report prepared for The Business Council on National Health Policy (January, 1994), p. 13.

### **Current Policy Considerations**

The early retiree element of President Clinton's health reform proposal has come under heavy criticism by some in the business community, especially by segments of it that do not sponsor retiree health benefits today. Recent public comments indicate that some policy makers are not favorably disposed to this aspect of the health reform proposal. There are even suggestions of dropping the early-retiree proposal from the package altogether. Given the analysis that we have developed here, it is not clear what dropping the early-retiree proposal might ultimately mean.

As indicated earlier, much of the savings for employers currently providing retiree health benefits would result from community rating, whether any other aspects of the proposal are implemented or not. To put the community rating factors into context, consider the larger population of 8.2 million people that we believe would be affected by the proposal. Moving to the community rate for these individuals would reduce their premiums by \$11.4 billion compared with what they would be at an experience rated level. If we assume this \$11.4 billion is going to be covered by increases in the premiums for workers and their

dependents, it would mean that every man, woman and child covered by an active employer plan under reform would have their annual premium raised approximately \$65 per year. Does eliminating the early retiree proposal mean that we eliminate community rating for early retirees? If you want to differentiate for early retirees, how do we distinguish "early retirees" from other people between ages 55 and 64 who are not working? If we do, what does that do to the underlying concepts of equity that pushed for community rating in the first place? If we do not, employers sponsoring retiree health benefits currently will still get a considerable benefit even if everything else affecting early retirees is thrown out of the package.

The second large element of the financing of the early retiree health benefits are the coverages that would be provided through employer plans for active employees. This coverage is the result of the mandate that active employees and their dependents be covered. Does eliminating the early retiree proposal mean that we eliminate the obligation of employers to provide coverage to workers during their shadow careers? If we do, what does such an exemption mean in the context of a proposal that is based on the concept of universal employer mandates? If we do not, employers currently sponsoring a retiree health benefit plan would likely be exempted from covering individuals during the period when they take up their shadow career. Will they come back later and provide retiree coverage when their former worker finally retires? Maybe in some cases, but in many they may conclude that the final employer has as much responsibility as they do in providing retiree benefits to the single worker that served them both.

Table 1 shows the government would pick up only \$1.1 billion in costs specifically due to the early retiree proposal. If you assume that the community rating, the employer mandate, and the governmental subsidies for low-income individuals remain in the Clinton package because of larger policy considerations, then that \$1.1 billion is all that would be shifted back to these employers if this provision is dropped. Evening adding that \$1.1 billion to the \$1.9 billion that employers would continue to pay under President Clinton's proposal would still significantly reduce their current commitments. It would seem that the only way

to leave them with additional obligations is to craft special taxes to levy against them or to fundamentally disassemble other aspects of the proposal. Crafting special taxes could be classified under the category of no good deed goes unpunished. Disassembling other aspects of the proposal would be the equivalent of the tail wagging the dog of public policy.

Senator WOFFORD. Thank you all. [Whereupon, at 4:37 p.m., the committee was adjourned.]



#### SECURITY ACT: MENTAL HEALTH THE SUBSTANCE ABUSE AND IN HEALTH HEALTH CARE REFORM

## TUESDAY, MARCH 8, 1994

U.S. SENATE, COMMITTEE ON LABOR AND HUMAN RESOURCES, Washington, DC.

The committee met, pursuant to notice, at 10:00 a.m., in room SD-430, Dirksen Senate Office Building, Senator Edward M. Ken-

nedy (chairman of the committee) presiding.

Present: Senators Kennedy, Pell, Metzenbaum, Simon, Harkin, Mikulski, Wellstone, Wofford, Jeffords, Coats, Thurmond, and Durenberger.

## OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. The committee will come to order. This is a very special day for the U.S. Senate, and a very special day for our Labor and Human Resources Committee on a matter of enormous importance to families in this country. We all want to make opening statements, but I will have mine printed in the record so that we will have the most time possible to hear two very, very extraordinary individuals who have provided exemplary leadership in an area of major importance and consequence for the American people.

We have with us today two incredible individuals who, after an enormous period of dedication to public service, could have enjoyed well-deserved time with their families and their loved ones. Instead, they have brought great light to this Nation and, in many respects, to the world, on a matter that deserves illumination: men-

tal illness and substance abuse.

At the outset, I want to acknowledge the very strong work of members of our committee, particularly Senator Wellstone and Senator Domenici, who are co-chairs of the Senate Working Group on Mental Health. They have brought together enormous diversity in the Senate on this issue, and all of us are very grateful for their powerful advocacy.

Before hearing the presentations of Mrs. Carter and Mrs. Ford, I will ask our ranking Republican and friend Senator Jeffords to make a brief comment, and then my co-chair today, Senator Wellstone. If others feel inclined, they certainly may also make

opening statements, following the rules.

We want to recognize that Senator Kassebaum was here earlier to join in the greetings before this hearing, but is now involved with an amendment on the Senate floor. She is strongly committed to mental health issues, and I know she wishes she could be here with us today.
I recognize Senator Jeffords.

[The prepared statement of Senator Kennedy follows:]

### PREPARED STATEMENT OF SENATOR KENNEDY

This is the third hearing by the Labor and Human Resources Committee in the past year on mental health care and substance abuse treatment in health reform.

Today's hearing is co-chaired by our colleague on the committee, Senator Wellstone, who has been an effective leader in the effort to ensure comprehensive mental health services and substance

abuse services for all Americans.

It is an honor to welcome two outstanding former First Ladies who have made an extraordinary difference in educating the public about these issues. The pioneering work of Rosalynn Carter and Betty Ford is responsible for much of the progress achieved so far.

Mrs. Carter and Mrs. Ford have worked closely with Tipper Gore toward the goal of developing a strong mental health and sub-stance abuse benefit in the health care reform bill we will consider this year. I commend them for their efforts and their commitment.

We will also have the privilege this morning of hearing from former Governor and former Senator Hughes of Iowa. During his years in the Senate, Harold Hughes worked hard to foster a better scientific understanding of alcohol and drug addiction, and he continues to be a leader in this field.

Substance abuse and mental illness take an enormous toll on American society. The breakdown of families, violence in communities, and homelessness on the streets are among the most serious

problems associated with these afflictions.

An estimated 20 percent of American adults suffer from depression or other forms of mental illness each year. Many of them would benefit from timely, cost-effective, mental health services. At least 12 percent of children and adolescents suffer from one or more mental disorders.

Substance abuse is a problem for an estimated 11 million Americans, but only a fourth of them have access to treatment. Many drug users are at great risk of contracting AIDS, tuberculosis and

other infectious diseases.

In addition to their impact on public health, substance abuse and mental illness are major economic problems. Directly and indirectly, they cost the nation over \$300 billion in 1990. The Center for Addiction and Substance Abuse has estimated that in 1991, one fifth of all Medicaid expenditures for inpatient hospital care were attributable to substance abuse.

Treatment can help reduce those costs significantly. One study documented a 40 percent reduction in health costs by substance abusers who complete treatment. Mental health care is associated with a 20 percent reduction in overall use of health services. Treat-

ment saves lives—and it also saves money.

Our goal is to see that mental health and substance abuse treatment are covered in health reform to the same extent as physical health treatment. A national poll released yesterday by the Bazelon Center for Mental Health Law found that 62 percent of Americans agree with this principle of parity. it also found that

Americans reject arbitrary limits on treatment.

Opponents continue to express their belief that an unrestricted benefit will cost too much, because it will cause more people to seek treatment. But partial benefits with arbitrary limits are more expensive because they lead to inadequate or delayed care, and higher future costs.

Our third panel of distinguished experts will share some of this new evidence with us this morning. Their work is demonstrating in different populations and different parts of the country—that a well-managed benefit, based less on expensive hospital care and more on outpatient or intermediate care, can treat more people,

more appropriately, at lower cost.

This latest research includes a managed care program in Massachusetts. Under a waiver obtained for 1992, the state lifted arbitrary caps on substance abuse and mental health treatment for its Medicaid beneficiaries, and saved \$47 million. The Massachusetts program raises important questions about how to assure that managed care does not lead to under-treatment, but an initial review of the program by Brandeis University suggests that the 22 percent reduction in costs was achieved without lowering the overall quality of services.

Substance abuse and mental illness annually cost our society more than cancer, lung disease, or heart disease. No one argues that we should not treat those diseases, or that we should treat them partially, because they are too expensive. As today's testimony will demonstrate, it is more expensive not to treat substance abuse and mental illness, and we must heed that lesson as we

move forward on health care reform.

I welcome all of our witnesses, and I look forward to their testimony.

## **OPENING STATEMENT OF SENATOR JEFFORDS**

Senator JEFFORDS. Thank you, Mr. Chairman.

I will uphold our long-known notoriety in New England for brevity and briefly State that it is incredibly important that you are here; we deeply appreciate it. It seems that we are going to have difficulty to get a parity for mental health with physical health.

There is an increasing awareness throughout this Nation, with all of us individually or our extended families, of how these problems permeate our society and need to be recognized as needing

help.

At the same time, we are learning by the various methods that are available that much can be done at lesser cost, and we have to work together among ourselves, but also with the mental health community, so that we can all work together to ensure the parity and ensure that we keep the costs in balance so that we will not have problems in that regard.

Thank you very much, Mr. Chairman. I appreciate your holding

this hearing.

[The prepared statement of Senator Jeffords follows:]

## PREPARED STATEMENT OF SENATOR JEFFORDS

Mr. Chairman, thank you for holding this hearing on one of the most important issues facing this Congress as we deliberate over what we must include in a comprehensive health care reform benefits package. We must not underestimate the significance of two very committed former first ladies—Mrs. Ford and Mrs. Carter testifying before this Committee. Their continued work in the area of

substance abuse and mental health is exceptional.

One point that we must address is that society pays an enormous price for addictive and mental disorders. In a recent report distributed by the Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services it was reported that—"this Nation's direct medical care costs and indirect costs (loss of productivity) of alcohol and other drug abuse and mental illness totalled more than \$314 billion in 1990." The report further emphasized that this was more than cancer, respiratory

disease, AIDS, or coronary heart disease.

Many of my constituents in Vermont have brought me study after study that show that patients diagnosed with mental illness are typically heavy users of medical services. If mental and substance abuse services are made available to these patients, medical utilization will decrease resulting in large savings to our health care system. In addition, constituents who have mental disorders and are currently on disability can't get health benefits in the current system because they have a preexisting condition. If they can't afford the medication that helps stabilize their condition they can't work and therefore remain on disability.

If we are serious about fixing our health care system we must realize the tremendous savings to our society by treating people with mental and substance abuse disorders in parity with other medical conditions. Our incidence of violent and other crime will go down, performance and productivity in the work force will go up, and people who want to work will be able to get off the disability

roles.

In my opinion we can not afford not to include a comprehensive benefit for mental and substance abuse in the benefit package. I will continue to work with my colleagues Senator Domenici and Senator Wellstone on the bipartisan Senate Working Group on Mental Health Benefits to ensure that we get this right. I'm looking forward to the testimony of all of the witnesses here today.

The CHAIRMAN. Thank you, Senator Jeffords.

Senator Wellstone?

## OPENING STATEMENT OF SENATOR WELLSTONE

Senator WELLSTONE. Thank you, Mr. Chairman.

I feel a bit awkward because I almost never make any kind of lengthy opening statement, and I will try and be very brief, but I care so fiercely about this issue. I would like to take a few moments, and for that I apologize. Usually I do not do this.

It is a real honor to co-chair this hearing with you today on the importance of comprehensive coverage for mental health and sub-

stance abuse as a part of health care reform.

Mr. Chairman, I have cared about this issue for a good part of my life, but you have been involved with this for many years in the Senate, and I would just thank you for your leadership. You could not have been more supportive of the work of all of us and the Senate Working Group on Mental Health and, I might add, substance abuse.

I would like to thank Senator Domenici, who has been a tremendously important leader when it comes to mental health benefits, as well as other members on this committee who are a part of that working group—Senators Simon, Kassebaum, Wofford, and Jef-

fords.

With us today, we have two individuals who have similarly given much of their lives to what I guess we could call this struggle. Together, you all today bring not only the forces of right and reason, but I think you can help us create the kind of political momentum that we need at this very, very critical time, and all of us are deep-

ly grateful to you for being here today.

This has not always been an easy issue to discuss with dignity in public, whether we are talking about mental health or whether we are talking about substance abuse. And even now, the stigma of mental illness and substance abuse keeps many of those in need from seeking help and prevents all too many policymakers from providing it. And voices like yours are so important in challenging some of these misguided assumptions.

We are very fortunate to have with us also former Senator Harold Hughes of Iowa, who has fought on these issues with such de-

termination.

For all too long, Mr. Chairman, mental health and substance abuse have been put in parentheses. We did not want to talk about it, we did not want to deal with it seriously. And the presence of these witnesses today and this committee hearing I think represents the fact that we have made a major breakthrough.

I also want to thank one other person, and that is Tipper Gore. She has been so knowledgeable and such a talented leader and has done so much to spearhead this reform effort that I think all of us

owe a great deal to her.

Finally—and I wanted to say even more, Mr. Chairman, but I will not—we do have a tremendous body of new evidence, some of which witnesses here today will discuss, which proves beyond a doubt that mental health and substance abuse disorders are diagnoseable, and they are treatable in a cost-effective manner. In fact, we can show that it costs less within a very short period of time to treat these disorders directly and appropriately than to not

treat them at all.

We are going to be dealing with some data throughout these hearings, and the only thing I want to say, Mr. Chairman, is that I think between the way in which we will have the power of this testimony, making these facts and figures real in human terms, and some of the excellent work CBO is now doing with Congressional Research Service to really challenge some of the actuarial numbers that we had which are outdated—sometimes they are just old ideas that we have to deal with—I think we can present the data that show that per covered person, we can provide comprehensive and flexible benefits, and make that a part of the mental

health and substance abuse package and make that a part of

health care reform in our country.

This is an opportunity of a generation, and we cannot miss it. And I want to say to both of you thank you for being here. I am with you and everyone on this committee each step of the way until we are able to achieve this goal. We can do it this session. We have to.

[The prepared statement of Senator Wellstone follows:]

### PREPARED STATEMENT OF SENATOR WELLSTONE

Senator Kennedy, it is a real honor to co-chair this hearing with you today on the importance of comprehensive coverage for mental health and substance abuse services as a part of health care reform. You have been an outspoken advocate for this issue for decades. You could not have been more supportive of my work as co-chair of the Senate Working Group on Mental Health, and I'm proud to be here at a time when we can really make a difference.

I have cared about this issue and talked about it for many years before I came to the Senate. I am tremendously gratified that I have had the opportunity to propose major health care reform legislation, the American Health Security Act, S. 491, which is the only major reform bill to cover comprehensive and flexible mental heath and substance abuse benefits. Like my resolution S.R. 107, which focuses specifically on these benefits, the American Health Security Act covers mental illness and substance abuse in absolutely the same way as any other illness, without arbitrary restrictions in days or payments.

I want to acknowledge the great contributions in this area by my colleague and co-chair of the Senate Working Group, Pete Domenici, as well as the other members of this Committee who are working with the Group: Senators Simon, Kassebaum, Wofford and Jef-

tords

We have with us today so many people who have similarly given much of their lives to this fight for fairness and recognition of mental disorders.). Former First Ladies Rosalynn Carter and Betty Ford are famous for their courage, their integrity, and their years of dedication to mental health and substance abuse treatment. Together, you bring to the Congress not only the forces of truth and reason, but also the ability to create the political momentum we so seriously need at this critical time to help us do what is right. All of us are deeply grateful to you.

This is still not an easy issue to discuss with dignity in public. The stigma of mental illness and substance abuse keeps many in need from seeking help, and prevents policy makers from providing it. Voices like yours are so important in challenging misconceptions. And we are fortunate today to have with us former Senator Harold Hughes of Iowa, who has also fought on these issues with

determination.

For far too long, mental health and substance abuse have been put in parentheses. We didn't want to talk about it, and we didn't want to take it seriously. The presence of these remarkable witnesses here with us today is only one sign that we are coming upon a breakthrough in care for mental illness and substance abuse.

President and Mrs. Clinton took an important step in including mental health and substance abuse coverage in their health care reform proposal. Mrs. Tipper Gore has been a knowledgeable and talented leader of the White House's task force on mental health, and has continued to advocate for the importance of this reform. We have a tremendous body of new evidence, some of which our other witnesses here today will discuss, proving without a doubt that mental health and substance abuse disorders are diagnosable and treatable in a cost-effective manner. In fact we can now show that within a very short period of time it costs less to treat these disorders directly and appropriately than not to treat them at all. We can say this is true based on studies of every sector of our population: insured and employed, uninsured and unemployed, people who now use the private system and people who use the public system. As we will hear later, medical costs actually decrease dramatically both for patients and their families when they are able to receive the proper care.

But we have some problems to overcome. The mental health and substance abuse benefits in the Clinton bill are important in no small part by virtue of the fact that they are included. Communitybased services that would help us keep people well and productive

are described and covered.

But old data and old ideas keep us from covering mental health and substance abuse care just the same as we would cover heart disease or diabetes or any other real illness, whether acute or chronic. There should not be separate limits on days of care, or separate 50% co-payments on outpatient and community-based care, and additional deductibles for inpatient care. These features serve only to delay or deny the care many people need, and these features are intensely discriminatory.

The American people are ahead of the politicians on this issue. The national poll released yesterday by the Bazelon Center for Mental Health Law corroborate an earlier poll in Parade Magazine, showing that Americans do not see a distinction between mental and physical illnesses, and they do not want them treated differently, either. In fact, people are more likely to support a health care plan that includes comprehensive coverage for mental health

and substance abuse without arbitrary limits.

In fact we can afford comprehensive and flexible mental health and substance abuse benefits. At our last hearing on this issue in this Committee, in November, 1993, we heard testimony from Hewitt Associates, which covers millions of people for private industry. They told us that the cost of a comprehensive benefit, with the flexibility to refer people to the least restrictive setting where they can get the best kind of care, would be lower than the estimate we get from the actuaries at the Health Care Financing Administration for a far more limited benefit. HCFA tells us the cost would be \$241 per person per year for a limited benefit, with high co-payments and deductibles. They based their estimates on data from as far back as 1982, before recent developments in medical management of many conditions, and in the delivery of high quality managed care.

Hewitt says we can cover all needed benefits for around \$200, and less if the benefits are managed well. In today's testimony Dr.

Ron Geraty will present the results of an analysis of employed, insured citizens which estimates that a comprehensive managed care benefit for mental health and substance abuse can be provided for only \$87 per person per year, which is far lower than the Health Care Financing Administration's estimate of \$141 per person per year for more limited benefits for a similar population. We will also hear today from health policy expert Henrick Harwood who will present evidence that comprehensive coverage for a full range of substance abuse treatment services can be provided for only \$46 per person per year, or about the same cost that the Administration has estimated, again for a limited benefit.

We have heard the argument that the uninsured will use far more services than people who now have insurance. This too has been refuted, most recently by Dr. Richard Frank who has shown that people who are currently uninsured will most likely increase their utilization by only 1% more than those currently insured.

their utilization by only 1% more than those currently insured.

The Senate Working Group on Mental Health, working with our companion House Working Group, has presented massive and compelling evidence on the effectiveness and cost efficiency of mental health and substance abuse treatment to the Congressional Research Service and the Congressional Budget Office, who are now taking a fresh look at the costs of health care reform. We included the 74 submissions received by this Committee following the hearing I chaired last November on this issue. I am glad to say that some of the witnesses who are with us today are communicating directly with CRS and CBO as a result of our efforts, and I am also glad to note that Mr. Hustead, who is working with CRS and CBO, is with us today both to hear more evidence and to enlighten us on his work.

And I am proud to say that Dr. Cindy Turnure from my own state of Minnesota is here today to tell us that in my state the public sector, long the dumping ground for people no one else could or would care for, has found an innovative way to integrate public services with the private sector in a system that has been working in the real world since 1988. People are receiving better care far less expensively (80% of their initial costs were recovered in just one year) than our old ways of just turning our backs and hoping

the problem would never touch us personally.

Mental illness and substance abuse have touched many of us personally. And for this reason and many other reasons this is not a partisan issue we are talking about here today. The Senate Working Group on Mental Health is a bipartisan group that wants to work for right and justice on this issue. That these two former First Ladies are before us today, representing both Democratic and Republican administrations, may be the best living example of how important it is to every one of us in Congress, and to every one of our constituents, that we make the most of the historic opportunity before us to enact meaningful health care reform legislation. The letter to Members of Congress that Mrs. Carter and Mrs. Ford will present to the Committee today is bound to have a galvanizing effect. I thank all of the witnesses who have come before us today to further this effort, and pledge that I will be with you in this effort all the way.

The CHAIRMAN. Thank you very much, Senator Wellstone.

Senator Coats?

### **OPENING STATEMENT OF SENATOR COATS**

Senator COATS. Mr. Chairman, we have such distinguished witnesses here, two women whom I and I think every American greatly admire and respect, and also Senator Hughes, whom I also greatly admire and respect. It would be presumptuous of me to take a lot of time, but just to say I asked myself the question: Why are these three individuals held in such high esteem by so many Americans? I think it is because they are public figures who have been willing to open their hearts and their souls and to be real people. And I think Americans admire that very much and admire the commitment that you have made to issues that touch the lives of just millions and millions of Americans. I respect that and appreciate it, and I look forward to your testimony.

The CHAIRMAN. Thank you, Senator Coats.

Senator Pell?

### **OPENING STATEMENT OF SENATOR PELL**

Senator PELL. Thank you, Mr. Chairman.

Mind and body cannot be separated. That is what this hearing

is all about.

I will ask that the balance of my statement be included in the record as if read, and congratulate you, Messrs. Chairmen, on holding this hearing.

The CHAIRMAN. Thank you very much, Senator Pell.

Senator Thurmond?

### **OPENING STATEMENT OF SENATOR THURMOND**

Senator Thurmond. Mr. Chairman, it is a pleasure to be here today to receive testimony concerning substance abuse and mental health treatment. I would like to join my colleagues in welcoming our witnesses here today. I would especially like to extend a warm welcome to former First Ladies Betty Ford and Rosalynn Carter, two wonderful people. I would also like to welcome back our former colleague Harold Hughes, who is doing such a fine job.

Mr. Chairman, I ask that my entire statement appear in the

record as if read.

The CHAIRMAN. It will so appear.

[The prepared statement of Senator Thurmond follows:]

### PREPARED STATEMENT OF SENATOR THURMOND

Mr. Chairman, it is a pleasure to be here today to receive testimony concerning substance abuse and mental health treatment. I would like to join my colleagues in welcoming our witnesses here today. I would especially like to extend a warm welcome to former First Ladies Betty Ford and Rosalynn Carter.

As you know, the cost to our nation caused by substance abuse and mental illness are tremendous. In 1990, Americans spent \$314 billion on the health and social problems created by drugs, alcohol, and mental disorders—\$100 billion more than the cost of AIDS and cancer combined. We pay not only in medical care costs, but in a

rising crime rate, in an overburdened social welfare system, in productivity losses, in premature deaths, and in the emotional suffer-

ing that can not be measured.

The importance of helping those who suffer from addictive and mental disorders is evident. Studies have shown that treatment programs can reduce the enormous social and economic costs of these disorders. For example, half of the patients receiving treatment for schizophrenia, either completely recover or can function with minimal support; thereby cutting rehospitalization rates, preventing homelessness, and improving employment outcomes for those patients.

Mr. Chairman, for every dollar spent on treating those with substance abuse problems, \$11.54 is saved in social costs. For example, the estimated 10 million alcoholics in this country spend two times more on health care than those without alcohol problems. Also, from 1991 to 1992, heroin-related emergency room visits increased

34 percent nationwide.

Costs associated with substance abuse are not limited to health care. Alcohol and drug abuse play prominent roles in violent crimes. Approximately fifty percent of all homicides are alcohol-related, and the Department of Justice estimates that by 1995, sixty-nine percent of the federal prison population will consist of drug offenders. After treatment, however, sixty-three percent of substance abusers will abstain from alcohol and other drugs for at least one year. Moreover, one study involving 44,000 people showed that arrest rates go down by three-quarters after treatment.

Addictive and mental disorders have added to our society's greatest problems: crime, joblessness, and welfare. Therefore, we can not

ignore the beneficial effects of prevention and treatment.

Again, I would like to welcome our witnesses here today, and I look forward to their testimony.

The CHAIRMAN. Senator Metzenbaum?

### OPENING STATEMENT OF SENATOR METZENBAUM

Senator METZENBAUM. Mr. Chairman, I am very pleased to see the two former First Ladies with us today, as well as my old friend

Harold Hughes, whom we miss in the Senate.

I think it is particularly important that we hold this hearing today because I think we are all aware of the fact that the legislation sent from the President does not provide, in my opinion, adequate provisions for those who are mentally ill—30 days of inpatient care and 30 days of outpatient care with a separate deductible. I think this is an issue to which we must address ourselves. It is a challenge to us because there is a cost factor involved, but I think with the help and leadership of both Mrs. Ford and Mrs. Carter, and the commitment and concern of so many members of this committee, we very well may be able to deal with the subject much more adequately.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Metzenbaum.

Senator Simon?

### OPENING STATEMENT OF SENATOR SIMON

Senator SIMON. Thank you, Mr. Chairman.

I just want to join in welcoming both of you. I am pleased that

you are standing up.

The reason that we have not done better in mental health and substance abuse is that there has been a stigma, and people have not stood up. So I am proud of both of you, proud of Harold Hughes, and I might add, Mr. Chairman, that I thank you for this, and Paul Wellstone, I thank you and our colleague Pete Domenici for your leadership on this as well.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Simon.

Senator Mikulski?

### OPENING STATEMENT OF SENATOR MIKULSKI

Senator MIKULSKI. Thank you, Mr. Chairman.

I too would ask unanimous consent that my statement be in the record, but with great admiration and respect, welcome the two First Ladies. Your lives have really proved the old adage that one person can make a difference, and then working together, we can

bring about change.

I think all of us know that the life of a First Lady is not an easy one and that you are often criticized for being either, if you recall, being under-involved or over-involved with so-called "petticoat politics." You have been the source of support for your families, but know that you and other First Ladies have been a source of inspiration for your country.

We thank you for the work you have done on substance abuse and giving people help on mental health. We regard with great respect the work that Mrs. Reagan has done on an anti-drug effort, Mrs. Bush on literacy, and now Mrs. Clinton on health insurance reform. This is truly an extraordinary country and the emerging role of what women can do through working together.

The CHAIRMAN. Thank you very much, Senator Mikulski.

Before we begin I have statements from Senators Pell, Dodd, Mi-

kulski, Wofford, and Hatch.

[The prepared statements of Senators Pell, Dodd, Mikulski, Wofford, and Hatch follow:]

## PREPARED STATEMENT OF SENATOR PELL

Mr. Chairman, I thank you for holding today's hearing to consider the need for mental health and substance abuse benefits in health care reform legislation. This is an important subject indeed,

and one that is of great concern to many Rhode Islanders.

I strongly believe that the mind and the body cannot be separated when it comes to health care. Those who suffer from a mental illness should receive the treatment that they need, just as do those who suffer from cancer or heart disease or any other physical illness.

And substance abuse—whether triggered by a need to relieve pain or by a misguided decision to try drugs for other purposes—is a physical addiction that can paralyze the mind and do serious

damage to the body. In almost every case, it causes pain to the in-

dividual and huge costs to society.

It is my hope that any reformed health care system will recognize the importance of coverage for both mental illness and substance abuse. And while we must consider the cost of providing such care, we must also consider carefully the cost of not providing this care.

Mr. Chairman, I am so delighted that today's witnesses include Mrs. Ford and Mrs. Carter. I have enormous respect for them both, and know how deeply committed they are to the issues that have brought them here today. The Nation owes a debt of gratitude to them, not only for their grace and dignity and many contributions as First Lady, but also for their continued commitment to public service in the years since. I am delighted to see them again and thank them very much for coming here today.

Thank you.

### PREPARED STATEMENT OF SENATOR DODD

Mr. Chairman, I am very pleased we are holding this hearing today because our topic is one that has received far too little attention during the health care debate. Mental illness and substance abuse are terrible medical and social problems, and despite what many might think, they are indispensable elements to health care.

I want to extend a special welcome to former First Ladies Rosalynn Carter and Betty Ford. Both have been tireless in their advocacy on these issues, and I am sure that they both have much

of importance to share with us today.

Mental illness and substance abuse not only directly affect physical health, but they also can be emotionally and financially devastating to sufferers and their families. The situation is not helped by the stigma attached to these problems and to many health insurance policies' lack of coverage for them.

Mental illness is a major but little-discussed problem in the United States. Studies have shown that mental health-related problems account for 20 percent of primary health care visits. For families with members suffering from mental illness, the cost for treatment—whether in-patient or out-patient—can be staggering.

Substance abuse, too, is extraordinarily expensive both for individual families and society at large. A study by the Johnson Foundation found that the abuse of alcohol, tobacco and other drugs cost the nation \$238 billion during 1990 in lost productivity, medical

costs, crime costs and destruction of property.

Substance abuse can also transmit health care problems from one generation to the next. We are all aware of the terrible problem of drug-exposed infants and children. This problem has recently received renewed attention because of reports of high numbers of "boarder babies," drug-exposed newborns abandoned by their parents in city hospitals.

We certainly cannot solve all our social problems through health care reform, but we can work to assure American families that they will not have to face these terrible problems without desperately needed medical help. I look forward to the opportunity we will have

today to examine these issues more closely.

### PREPARED STATEMENT OF SENATOR MIKULSKI

Good morning and thank you, Mr. Chair for holding this very important hearing. I would also like to welcome our distinguished first panel. It is an honor to be sitting here with two former First Ladies who have been at the forefront of this very important issue.

I think with the introduction of the Health Security Act, the President made a great step forward. Finally, substance abuse and

mental health disorders are recognized as treatable illnesses.

This is a step forward that I am pleased to see. But it is only a first step. I am looking forward to 2001 when the arbitrary limits imposed on mental health-and substance abuse benefits will be lifted. I firmly believe mental health and substance abuse illnesses should be treated with the same type of comprehensive and flexible approach afforded other conditions.

These illnesses affect millions of Americans every year. More than 30 million American adults suffer from mental disorders in any one year. An additional 10.5 million adults suffer from sub-

stance abuse disorders.

In fact, more people suffer from mental illness than are victims

of cardiac illness in any given year.

Mental health care is also critical for women's health. A women's risk for most types of depression exceeds that of men by two to one. Women suffer more from phobias and panic disorder as compared to men and account for most life-threatening eating disorders.

Women's substance abuse rates are rising. Prescription drug misuse and abuse is a serious an real danger for women. Approximately 70% of the prescriptions for antidepressants are given to

women.

According to an article in the Journal of the American Medical Association in September of 1993, alcohol-related hospitalizations among the elderly are common. The prevalence of alcoholism among elderly in acute care hospital settings has been estimated

to be as high as 20%.

All of these numbers show how common are the dual problems of mental health and substance abuse. It is the time to recognize that your mother, sister, brother, grandfather could be suffering from one of these debilitating conditions. We have started to overcome the stigma and move forward to offer appropriate treatment with the Health Security Act. We must continue to take these steps forward.

## PREPARED STATEMENT OF SENATOR WOFFORD

Thank you and welcome to our guests and panelists. I would like to extend a particularly warm welcome to Mrs. Carter, Mrs. Ford, and former Senator Hughes. Our health reform efforts must build on the knowledge and expertise of those who have pioneered in their fields and we could not have gathered a more distinguished or more qualified panel to educate us today. We have before us people who have already made a real difference in the fight for comprehensive treatment of mental health and substance abuse disorders.

Health reform gives us the historic opportunity to recognize that our nation's health and well-being will not be improved unless we address our physical and mental health together and offer a continuum of treatment to address all levels of need. The Health Security Act seizes this opportunity and takes the crucial steps of including coverage for mental health and substance abuse treatment in the comprehensive benefits package, and eliminates historical exclu-

sions for based on preexisting conditions.

These are crucial steps and we must ensure that they are done right, so that coverage for mental health and substance abuse disorders results in a decrease in their incidence. We must ensure that the benefit is one that consumers can access when needed and providers can use to deliver the most appropriate treatment. As we will hear from witnesses today, including a comprehensive, flexible benefit for mental health and substance abuse is the way to do this right—results in the best outcomes and is the most cost-effective. Furthermore, limiting benefits on the private side will only increase costs on the public side. I recently heard from our Philadelphia Health Commissioner that the fastest growing population they serve for mental health services are people who have exhausted their private insurance benefit.

The evidence is mounting that we cannot afford not to do this right—the human and economic costs of not treating mental and substance abuse disorders is only increasing. Providers in Pennsylvania have pointed out to me that it is fairly simple: untreated mental and substance abuse disorders drive up health care costs, and treatment brings costs down—not only health care costs, but costs to the criminal justice system, education, and lost productivity. Just a few of the many supporting statistics support their as-

sertions:

One of every 5 dollars Medicaid spends on hospital care is attributable to untreated substance abuse: in Pennsylvania, that figure comes out to about \$1 billion of the state's \$5 billion Medicaid

budget.

Untreated addicted people use health insurance and Medicaid at rates up to 10 to 12 times more frequently than the general public for addiction related illnesses and accidents: after treatment of the addiction, health care spending drops dramatically, and often converges with the health care use of general populations.

Studies have shown that those who need psychological care yet do not receive it visit medical doctors twice as often for unneces-

sary care as those who receive treatment.

Depression alone costs the economy \$43.7 billion/year: only \$12.4 billion of this cost is treatment—the rest is from areas such as lost

income from decreased productivity.

One drug and alcohol addicted baby in a neonatal intensive care unit costs 20-40,000. And that's just the cost of the first few days of life, not the cost of lifetime assistance that may be needed for

physical or mental disabilities.

Pennsylvania has recognized the costs and benefits of addiction and passed legislation that requires private health plans to cover substance abuse treatment. No additional cost was attributed to the mandate when it was passed, recognizing the significant offsets in saved health care costs that would result from providing treatment for addiction. We have before us an opportunity we cannot let pass by, and we must learn from those who have gone before us to try and do it right. As we proceed, there are several areas of concern that have

been raised with me that I want to ensure are addressed:

We must ensure that the benefit is truly universal. Long term treatment is vital part of the continuum of care, particularly for some populations traditionally covered by public programs. As we try and end our two tier health system, we must ensure that the new system addresses the need for long term treatment.

Consumer protections must be in place that gnarante

Consumer protections must be in place that gnarantee that those who need treatment will receive it. Protections must include ensuring that a qualified health professional is responsible for assessing patients' needs, and that sound criteria are used in determining placement, such as those developed by the American Society of Addiction Medicine.

As we move towards non-hospital rehabilitation, we must ensure there are sufficient hospital rehabilitation facilities available for patients. Pennsylvania is again ahead of the curve—there are over 100 non-hospital rehabs, and only about 10 hospital rehab facilities in the state—but not every state has moved this far. We must also recognize that hospital-based rehabilitation is necessary at times.

and thus essential to a full continuum of care.

Last but definitely not least, we must recognize and support our community providers who have been delivering this care. In Pennsylvania, a thirty year old county-based and locally-run system of Community Mental Health, Mental Retardation, and Drug and Alcohol providers have been expanding and developing an array of community services. When the Commonwealth closed a state mental health institution in Philadelphia, the community mental health system developed a system of care for the patients, including enhanced services to meet the population's diverse long term needs, that is considered a model in community-based care.

Thank you again to our distinguished witnesses. I look forward to hearing your testimony and working with you in the months ahead to try and improve our nation's health and well-being by addressing our physical and mental health needs together and guaranteeing a continuum of treatment that will meet all levels of need.

## PREPARED STATEMENT OF SENATOR HATCH

Thank you Mr. Chairman.

I would like to join in welcoming our distinguished guests.

I think the presence of Mrs. Ford and Mrs. Carter bears testimony to the critical need for health care coverage for mental health and substance abuse, which we will be discussing in today's hearing. I want to take this opportunity to personally express my sincere appreciation for their untiring work and dedication to these very important issues.

As our witnesses today will underscore, almost every member our society has been touched, in some way, either directly or indirectly, by mental health and addictive disorders. The tragedy of these afflictions can be observed not only in the great pain and suffering they wreak on the afflicted, their family and friends, but also in the

immeasurable economic and social disruptions they cause.

Currently, as many as 30 million Americans have a diagnosable mental disorder—this is a conservative estimate. Mrs. Gore, a leading figure in the mental health arena, has told the Committee that over 52 million Americans have been diagnosed as having some sort of mental issue in any given year. Unfortunately, fewer than one third receive appropriate treatment.

Mental illness and substance abuse affect a significant portion of our populace, and treatment for the spectrum of these disorders is

costly.

Clearly, mental health and substance abuse coverage must be a vital part of any debate on health care reform. As we strive to improve our health care delivery system, we must make every effort to ensure that people have access to services and treatment for mental and addictive disorders, which are delivered in a cost-efficient manner, in the appropriate setting, by the appropriate pro-

vider, with skill and compassion.

This is a critical issue, as evidenced by our distinguished guests today, including Mrs. Ford and Mrs. Carter. This Committee has an excellent record of providing appropriate Federal support to combat mental illness and substance abuse disorders, and I hope we will maintain that record as this dialogue continues. Once again I thank you, and our other expert witnesses, for appearing before us today. I look forward to hearing your testimony.

The CHAIRMAN. It is a special honor to welcome our first panel

of former First Ladies, Rosalynn Carter and Betty Ford.

Mrs. Carter was the driving force behind and honorary chair of President Carter's Commission on Mental Health and did an excellent job, earning bipartisan respect in Congress. She testified before this committee in support of that legislation, and one of the tangible results of her leadership was the passage by Congress of the landmark Mental Health Systems Act of 1980, which enacted many of the recommendations of the commission and expanded and restructured Federal aid for mental health services.

Today she chairs the Carter Center Mental Health Task Force, which she created and which has become a respected advisory group of experts, consumers and advocates for improvements in

mental health services.

Mrs. Ford deserves great credit as well for her active and effective leadership in all aspects—awareness, education and treatment—of substance abuse. Today she is president of the board of directors of the Betty Ford Center, which opened in California in 1982 and has earned an outstanding reputation as one of the preeminent facilities in this Nation for the treatment of substance abuse. She is a recipient of the Presidential Medal of Freedom for her work on these and other issues.

As a matter of agreement, we will start with Mrs. Ford.

# STATEMENTS OF FORMER FIRST LADIES BETTY FORD AND ROSALYNN CARTER

Mrs. FORD. Thank you, Mr. Chairman and members of the committee. I deeply appreciate the opportunity and the honor of appearing before you with Mrs. Carter.

Rosalynn and I represent two parts of an issue we believe may be shunted aside in the move to reform our health care system. Such an omission presents a great danger for the future success of

this reform.

Substance abuse is not an expensive add-on to an already strained system. Recent studies of overall health care spending indicate that substance abuse treatment comprises only one to 3 percent of medical costs.

Such treatment is an important cost saving component of health care reform. Society will reap large benefits immediately and recur-

rently from such coverage.

As I continue my testimony, I will refer to alcohol and drug de-

pendence—this is a more accurate term for substance abuse.

Alcohol and drug dependence is a major underlying element throughout our health care and throughout every aspect of our society—business and industry, the criminal justice system, social

services and education.

I know that treatment for alcohol and drug dependence works. There are no guarantees for success for every person who undergoes treatment, but the standard of successful treatment programs reflects a success rate of about 65 to 70 percent. This exceeds the recovery rates of most other chronic diseases.

I know from my personal and professional experience that substance abuse is a chronic disease, one that can be diagnosed and successfully treated. The American Medical Association and the World Health Organization designated it a disease as early as

1956.

Today, the cost associated for individuals with alcohol and drug dependence undermines the chance of reform as surely as the disease destroys thousands and thousands of American lives each

ear.

Several recent economic studies indicate that by assuring the availability of alcohol and drug treatment services under health care reform, we can save enormous sums of money in the long run. The President's Commission on Model State Drug Laws states that for every dollar spent for treatment, \$10 are returned to the econ-

omy.

Untreated, alcohol and drug dependence results in excessive medical and social costs which inflate the number of dollars spent for health care in this country. Studies, including one done by the Robert Wood Johnson Foundation, place the current cost estimate at \$240 billion annually. That is roughly \$1,000 for every man, woman and child in American. The American Medical Association estimates that alcohol and drug dependence is responsible for at least 40 percent of all hospitalizations.

Alcohol and drug dependence devastates families both emotionally and financially. One out of four Americans experience family problems directly linked to alcohol and drug dependence. It plays a part in one-third of all failed marriages. It is suspected that more than 50 percent of the domestic violence against women occurs under the influence of drugs and alcohol. The corresponding toll on

the children involved is impossible to calculate.

A recent Gallup poll indicated that over 70 percent of Americans believe that alcohol and drug dependence is a disease that should be treated in a hospital or health care institution. Those who are fortunate enough to receive help represent a sizable net benefit for health care. Hospitalization rates are cut in half after treatment. Emergency room use, medical and psychiatric admissions all are

significantly reduced after treatment.

These savings can be extended to family members as well. The recently released evaluation for the President's Commission indicates that "Health care claims of family members when their alcoholic relative received appropriate treatment fell off by 50 percent."

Successful, quality treatment can yield other excellent returns. Absenteeism and job-related problems show marked reductions after treatment, and this yields tremendous savings to industry. Auto accidents and arrests decrease fourfold after treatment. This reduction provides real savings in insurance and public safety costs. Treatment for addiction is one of the few areas of health care where the treatment received will make a long-term contribution to the reduction of health care costs.

Reform is taking place now. For that reform to be effective, I am convinced a comprehensive benefit covering quality treatment of alcohol and drug dependence and mental illness must be a significant part of any legislative package. There is indeed a cost involved at the time of treatment, but the rewards and the cost savings for the

future will be multiplied many times over.

Secretary Joe Califano, now chairman of the Center on Addiction and Substance Abuse, may have put the issue most succinctly, and I quote: "Without an all-out attack on the Nation's number one health problem—substance abuse and addiction—reforms designed to provide health care for all Americans at a reasonable cost are doomed to fail." I agree wholeheartedly with this evaluation.

Mr. Califano is now at the forefront of telling us that without addressing alcohol and drug dependence, we cannot achieve reform. And we need that reform. We cannot afford the lives or the dollars

at risk if we want for Mr. Califano to be proved right.

I applaud the members of the committee who were part of the group who sent a letter to Ira Magaziner this past November. I was very pleased that in that letter, you opposed setting arbitrary, predetermined limits on treatment for mental health and substance abuse.

I sincerely ask you, all of the members of the Senate Committee on Labor and Human Resources, to give careful consideration to this issue in all its enormity. This is a plea Mrs. Carter and I are making to all the Members of Congress in a letter that is being

sent out today.

Thank you for the kindness and consideration you have shown in allowing me to testify. Having the privilege of serving this Nation as First Lady, I realize the responsibility of speaking out on issues that concern our country. I certainly appreciate this unique opportunity that you have given Rosalynn and me to appear here today.

The prepared statement of Mrs. Ford may be found in the ap-

pendix.

The CHAIRMAN. Thank you very much.

Mrs. Carter?

Mrs. CARTER. I want to thank you, Mr. Chairman, and all the members of the committee for having us here today. And Senator Wellstone, I guess I am finally honoring my earlier promise to you

to appear here, and I would like to thank you for your original invitation and for your patience with me.

It is a great pleasure for me to be here and a great pleasure for me to be working on this issue with Betty Ford. We had a day yes-

terday, getting our message out; we did a lot of press.

I know that many of you know that I have had a longstanding interest in mental health and the needs of people suffering from mental illnesses. And Betty has been such a wonderful advocate and role model for those suffering from substance abuse and addictions.

So when Betty and I talked several weeks ago, we realized that we were both becoming more and more concerned about what was happening to the mental health and substance abuse benefits in health care reform. And as a result of that discussion, we decided to work together to see if we could do something to increase public awareness about the scope of mental illness and substance abuse problems in our country and also to let people know that we have a great opportunity now with health care reform to do something significant, to take a significant step in providing adequate, appropriate health care for those suffering from these illnesses. That step is adequate, appropriate coverage in any health care program adopted by Congress.

Our goal is to have mental illnesses and substance abuse treated equally with physical illnesses in health care reform. We should not any longer determine the need for treatment by diagnosis—if one person has this, they can receive treatment, but if they have another illness, they cannot receive treatment. That is not right. If you are sick, you are sick, and treatment should be available for

those who need care.

I am really pleased by the results of a survey that were announced yesterday by the Bazelon Center. This is a poll that was just done the last of February, and it shows that two out of three voters agree that coverage of mental illness and addiction is just as important as coverage of physical illness. They should be covered the same.

It is our hope that through our appearance before you today, we can convey what we believe to be some very compelling reasons for including mental illness and addictive disorders fully in health care

reform.

And then, later today, Mrs. Ford and I are going to send a letter to all the Members of Congress regarding our concerns and our position.

What are the reasons? Mental illnesses are real, and they are a very serious problem. A recent study by the University of Michigan estimates that three out of ten Americans will suffer a mental disorder this year. And throughout the course of our lives, one-half of all Americans will experience at least one episode of a serious emotional problem.

In this same study, of those with the most serious and multiple problems, only one-third of them received any treatment in the pre-

vious year.

And 12 percent of our children—millions of our children—suffer from emotional and mental illnesses. And the same thing is true there—only one out of three receive any treatment. And in our poll,

85 percent of the people believed that children should be covered totally. We are really, really excited about this poll.

Major depression accounts for more bed days—people out of work and in bed—than any disorder except for cardiovascular disease.

Mental illnesses are real.

Research in the last decade has made it clear that some of the major mental illnesses are related to chemical and/or structural problems of the brain. They are illnesses just like physical illnesses. And the majority of the voters now understand this to be

true, as we learned in this study.

We also learned from this survey, Mr. Chairman and members of the committee, that it would be a net plus for you to vote for coverage equal to that of physical illnesses, because only 16 percent of the people in the survey said they would be less likely to vote for health care reform if it included mental health coverage; 39 percent said they would be more likely to vote for health care reform if it included mental health coverage; and 20 percent said they would vote for health care reform not matter what it had, because we need health care reform. That left a small margin of people who said that they did not know.

But I think it is so exciting that people want mental health coverage in any kind of health care reform. I think that shows how far we have come over the past years in educating people about

mental illnesses.

The cost of treating mental illnesses in our health care budget has over the years been from 10 to 15 percent of the total health care costs, but the indirect costs are far greater than this 10 to 15 percent. Think of the lost productivity in the workplace—so much more absenteeism, so much more turnover in the employees who suffer from mental illnesses.

We pay for it in the loss of people's lives by suicide; in the welfare system; in the criminal justice system, with people in jail and in prisons; the homeless on the streets of our cities. And people with mental illnesses have more physical illnesses. If you are sick and not feeling good, you go to the doctor more. So we would save on physical health costs.

What we hope that people understand is that physical illnesses are as definable as mental illnesses. Mental health clinicians agree on a diagnosis 80 percent of the time, and that compares with the amounts of time that doctors agree on major mental illnesses or

many physical illnesses.

Mental illnesses are treatable, and some of the treatment are more effective than treatments for some physical illnesses. Schizophrenia, for instance. The efficacy rate of schizophrenia is 60 percent; for panic disorders, it is 80 percent; and for manic-depressive illness, it is 80 percent. The efficacy rate for angioplasty is 41 percent and for atherectomy, another heart procedure, it is 52 percent.

So mental illnesses are treatable, and the treatment is cost-effec-

tive.

There is increasing evidence from many of our larger corporations that a full, comprehensive managed mental health benefit is effective in dealing with mental health problems, and it reduces the overall costs of health care generally. Under the Federal Employees Health Benefits Plan, patients with chronic medical diseases who received psychotherapy for their emotional problems used 56 percent fewer medical services than

those who did not receive psychotherapy.

Large employers have been successful in saving money through redesign of their mental health benefit. One example is McDonnell Douglas, whom you have probably heard about. They introduced a managed mental health employee assistance plan which focused on individualized patient care planning and long-term care management. Employee absenteeism and turnover rates were reduced. During the first year, per capita costs declined by 34 percent, psychiatric inpatient costs decreased by 50 percent, and chemical dependency inpatient costs dropped by 29 percent.

If people can get appropriate mental health care at the appropriate time, in so many instances, with outpatient and clinical services, they can avoid the costly hospitalization and long-term care. That is what is so important in providing good mental health

care for people who suffer.

Review of plans that provide the best benefits have shown that mental health costs have remained between 11 and 13 percent for 20 years. And in Canada, where mental health is covered totally, mental health benefits have not gone over 14 percent of total costs. And I will remind you that the mental health cost for our health care is now between 10 and 15 percent. So providing mental health benefits is not a bottomless pit. Those who think that providing mental health care is a bottomless pit are not familiar with the new treatments.

Just since we left the White House in the last decade, almost everything has changed about treatments for mental illnesses. We have more information about the brain. We have new medications. We are seeing that outpatient and clinical services can benefit and

are effective with people who have mental illnesses.

And in addition to the great financial costs of reacting to mental illnesses—which is what we do now, instead of planning for the future and helping people and preventing these diseases; we just take care of them after they are very, very sick—but think of the human cost of the suffering of people with lives unnecessarily lost. Without treatment, we take away the opportunity of these individuals to participate in just the activities of daily life. And the impact of these disorders on the children, the families, and even on the communities is incalculable. The cost of lack of treatment results in untold pain and suffering.

We have an opportunity now to bring some significant progress in health care reform, and I refer to those proposals that all people will have coverage, that no one will be excluded based on preexisting condition, that health screening will also include screening for mental health problems, and that mentally ill people will finally have access to physical health care which has been denied because

of lack of insurance for those who have the problem.

But some of the current proposals continue to be problematic. The proposal that there should be arbitrary limits imposed on either the number of visits or the amount of care is one of those. And I mentioned earlier that American voters do not agree that we should have arbitrary limits. They want mental health included,

but they want strict standards and criteria, and they want the mental illnesses diagnosed by a professional, and they also want a review process to determine if the treatment is appropriate and to

rout out any that is not appropriate.

Limiting the number of treatments arbitrarily, without regard to the individual's need or to the severity or complexity of the problem, makes no sense at all. We would not think of placing a limit on the number of radiation treatments for cancer, no matter the size or the location or the growth of the tumor. Why do we limit the treatments for mental illness? So often, in mental illness and substance abuse, this just leads to a revolving door where they come back and back and back if they do not get the treatment that is needed.

Another problem is the copayment requirement, which makes treatment so expensive that many people will not be able to receive

it.

Another problem is the delay in full coverage for mental illnesses over several years. This is particularly offensive to me because when my husband was President, I worked so hard to get the Mental Health Systems Act passed. It was passed in September of 1980. A few months later, a new President was elected, and by

February of the next year, my bill was gone.

Mental illnesses and the treatment for mental illnesses is too important to be delayed or to be phased in. Individuals with mental illness have long experienced stigma and discrimination as a result of the myths and false stereotypes that have prevailed. As a result, they have been excluded from the mainstream of American life in housing, in employment, and in health care. We have a chance now to correct this with health care reform.

Let me end by saying that health care reform also holds great promise to do something significant for our children who suffer from serious emotional problems, millions of children in our country. I would raise the possibility that for our children, we think of taking a bold step forward to provide comprehensive services for them so that we can reduce the number of wasted lives of so many children and the painful separations from families, which is not

necessary and not good.

We have a chance to end the historic discrimination against people with these disorders. I have always thought that if insurance covered mental illnesses, they would be acceptable. If you could get insurance coverage or payment for treatment for mental illness, then it would be acceptable to have a mental illness. I think that would go as far as anything to help overcome the stigma. And it is urgent that we do it now, because if we fail to provide coverage for those who are suffering and need help and deserve help, we will not have another chance like this for a long, long time. It may be another generation before we will have this opportunity again.

So Mr. Chairman, we cannot afford to fail this time. Thank you. [The prepared statement of Mrs. Carter may be found in the ap-

pendix.]

The CHAIRMAN. Thank you very much. I will ask that the clerk remind each member when 7 minutes have expired so that we will all have an opportunity to inquire.

In very plain words, we are going to attempt with health care reform to provide medically necessary treatment for all Americans. Yet the question, with regard to mental health coverage, is will coverage have arbitrary limits? We do not have them for other health services, we should not have them here. That is a very powerful point, and I appreciate your reviewing with us the reasons historically why we have limits and suggesting that we let the bottom line inform decisions about how many days are allowed and at what cost.

You have reminded us, as we are as an institution reviewing costs, that we are not really considering the total cost. But I think the most powerful aspect of your testimony is showing us that we are not really reviewing in a humane and decent way the human suffering and tragic human costs to individuals who are denied the

kind of treatment that we know can help them.

That is what this hearing is about, and with the power of your testimony here, we can hopefully move this institution and the American people to the point that you advocate. We do not put restrictions on treatment that is medically necessary for physical health needs, and we should not put restrictions on treatment for

mental illness and substance abuse.

We, as an institution have to be able to justify these benefits beyond the human suffering to what the impact is on a child or a family when treatment is not available, and all of the other costs in terms of society. But I think the point that you make very powerfully is that treating the individual in a holistic way is cost-effective.

In my own State, which is treating both Medicaid and State employees holistically, I have seen the bottom line savings; it is less expensive, let alone what it means for the people who are treated. Those are the results in my own State in the studies that have been done there. It is more effective and, quality-wise, first-rate.

We have heard testimony last May from Bell South in California, with 30,000 employees, that "while the number of patients and the length of stay have declined for inpatient care, treatments delivered in partial hospitalization programs and doctors' offices have expanded over 300 percent and 13 percent respectively. The paradox of this approach is that Bell South has experienced a 20 percent reduction in mental health costs over the past 5 years, with treatment and mental health diagnoses declining to 14 percent of all hospital days and 8 percent of total health care payments. The redesign of benefits has allowed patients to be moved rapidly to a lower and more appropriate level of care." Bottom line savings for American business. That is the bottom line.

Let me ask a question about the stigma attached to mental illness. My family has seen it with mental retardation, and there clearly is a stigmatization today for mental illness. Why do you think that a decent and humane and fair-minded society holds that kind of attitude, and what do you think we all can do to try to deal

with that? Mrs. Ford?

Mrs. FORD. Mr. Chairman, I think that some of the stigma which is associated with mental health and substance abuse, or alcohol and drug dependence, is because the coverage is minimal, and that in effect stigmatizes the disease. People are seeing other diseases covered in their entirety, and so automatically, there is a lot of fear about these diseases because they are very misunderstood. And when you have fear of the unknown and misunderstanding, there is a stigma related to that.

We have to do a better job, of course, educating the public. We hope, Rosalynn and I, that in coming before you and the fact that your committee will address this, that we can remove some of the

stigma, and we certainly are very grateful for that support.

The CHAIRMAN. Mrs. Carter?

Mrs. Carter. Mr. Chairman, I think that the stigma has been, I would say, inherited into the health care proposals because of the arbitrary limits and those kinds of things. And the stigma comes from in the past, not understanding mental illnesses. In the past, anybody who had a mental illness was just sent away, put in an institution or a hospital. Everything has changed now. There are new treatments, new medications, new ways to treat people with mental illnesses now with outpatient and clinical services.

It is the same with physical illnesses. When somebody had surgery in the past, we used to put them in the hospital for days and days and days. Now they have a surgical procedure, they are up in an hour, and they are home the next day. Sometimes, they go into the hospital for a day for surgery and go home the same day.

The same thing has happened with treatment for mental illnesses. If people can have the appropriate treatment at the appropriate time, in the beginning of an illness, before it develops into something that has to take a lifetime of treatment, we can save money. It is not just the human costs, which are tragic, but it is the financial costs as well. It is cost-effective to treat those people who have mental illnesses and substance abuse.

The CHAIRMAN. My time is just about up, but do you think that, in the past, people thought that if someone needed treatment for mental illness, that it had more to do with that individual's behavior, rather than being a treatable disease? Do you think that progress has been made in diagnosing and treating individuals?

Mrs. Carter. I do not think there is any doubt about it. As I said, since we left the White House, there is so much that has been learned about the brain, the function of the brain, and about new medications that are effective, about new ways to treat people with mental illnesses. I think the stigma came from a lack of understanding, not knowing how to deal with the problem, not knowing how to deal with people who had mental illnesses, so we just put them away.

Now that we understand some of the causes for it, and we have

the new treatments, it is a totally different picture.

The CHAIRMAN. In the enforcement of the Americans with Disabilities Act, we find that individual workers with schizophrenia, as long as they can get treatment, perform magnificently on the job. They are productive workers, individuals and citizens. They just need accessible treatment.

Mrs. CARTER. So many people with mental illnesses can lead productive lives instead of becoming wards of the State if we just give

them the right treatment.

The CHAIRMAN. Getting people who would not be able to work out and involved in the community and as taxpayers makes a difference doesn't it?

Mrs. CARTER. Yes.

The CHAIRMAN. Senator Jeffords?

Senator JEFFORDS. Thank you, Mr. Chairman. I will follow up on

your questioning.

First, again, Mrs. Kassebaum wants me to express her deep concern that she could not be here. She wanted to, but her amendment is up on the floor right now. She certainly has been a leader in this area.

I would also like to follow up on the line of questioning about the stigmatization. It seems to me it also carries over into the professions in that we have had a mental health and a physical health stigma among themselves in that sense, not working together like they should. It seems to me that that also has been enhanced by the benefit side of the picture.

Would you agree with that statement?

Mrs. Carter. I think so, yes. I have always thought that we should have more education in health training education of physical health for mental illnesses so that physical health doctors can recognize mental illnesses, because so many people who go to the doctor for physical health treatment have mental illnesses. If doctors could recognize that, then people could be treated for their mental illnesses, and that also would save on the health care costs. But I think there has been a stigma, yes. I hope we are overcoming that.

Senator JEFFORDS. Do you agree, Mrs. Ford?

Mrs. Ford. Senator, I agree with Mrs. Carter about that. Certainly in the field of alcohol and drug dependence, doctors, physicians are very likely to overlook that kind of dependence, not only because they have not been trained in the field—there is very little training in medical schools—but also because not knowing how to address it or how to diagnose it or how to write the recommendations for it, they would overlook it and hope that they would not lose that patient by referring him to a specialist in that field.

Senator Jeffords. So I take it from your testimony that you

Senator JEFFORDS. So I take it from your testimony that you would agree that an important goal of our health care reform ought to be to try to reduce this division between the two and try to bring

the two professions together.

My second question is now in the mental health area itself, where we have a real competitiveness between residential care, nonresidential care, community health, psychologists, psychiatrists,

and that that is not a very effective system.

I have been talking with people who are trying to integrate the systems, where they have shown cost reductions of up to 40 percent by having a system with residential, partial residential and so on. Have you seen those kinds of plans out there, working, and do you think there is a way to integrate the system both physically and mentally so that we can get more efficiency and get better health care?

Mrs. Carter. I think health care reform gives us the best opportunity we have had in a long time to do that. If we just consider that people who are sick are sick, that they are suffering just as

much if they have a mental illness as if they have a physical illnesses, and that they should be treated, I think that we can overcome that. There will have to be some strict standards and criteria, and professionals who can diagnose an illness. But I do think we

can bring the systems together.

From the survey that we have just gotten the results from, people are beginning to understand this, and I think if people are beginning to understand it, surely doctors and mental health professionals are beginning to understand it, too. And if we can just bring everybody together to treat the person in a holistic way, then I think we can make so much more progress, and in the long run, reduce costs tremendously of health care.

Senator JEFFORDS. Mrs. Ford?

Mrs. Ford. I believe that with correct diagnosis and evaluation, those people suffering with mental illness and substance abuse can be put in programs that are appropriate for their care. And in doing that, you will be able to use outpatient programs as well as inpatient, and hospitalization, but only in extreme crisis situations. And of course, the difference in cost is tremendous. And the sooner they are diagnosed and evaluated and put into treatment, they have a much better chance of being less costly to not only the medical system, but the justice system, and employees, as far as going back and getting back on the job. So it is cost-effective across the board for our whole country.

Senator JEFFORDS. Finally, there was an HHS study done in 1990 which indicated that for every dollar we spend on mental health, that probably \$2 are lost in productivity which could have been saved if we had had more effective health care treatment. Do you feel that that is probably a reasonable estimate, or conserv-

ative, or liberal?

Mrs. FORD. Well, I would say that for every dollar we spend on health care for mental health and substance abuse, there is probably a much greater savings than almost any other type of chronic or acute disease that we treat, because just as we have all discussed here, these people can be put—most of them, more than the majority—back into very productive positions in our economy, and

that makes a big difference.

Mrs. Carter. I do not know whether 2 percent is a good figure or not on lost productivity. I know that there are great savings in productivity in these major corporations that have tried carefully managed plans. People are not absent as much; there is not that turnover rate among employees. But also think of the savings to the welfare system when people can work and be productive; to keep people out of jails and prisons; the homeless people on the streets—some people estimate a third, but I think that more than a third of the homeless on the streets suffer from mental illnesses—think of all of the indirect savings from giving good, appropriate care to those who suffer from mental illnesses and substance abuse.

Senator JEFFORDS. Thank you both very much. Your testimony

has been very helpful.

The CHAIRMAN. Senator Wellstone?

Senator WELLSTONE. Thank you, Mr. Chairman.

Mr. Chairman, earlier, I mentioned the work of Senator Domenici, but I do not think he would be upset with me if I said that the real work has been done by Nancy Domenici, who is here today. She has just been a real heroine in bringing this all to the forefront, and I would like to recognize Nancy Domenici, who is here today at this hearing, and thank her for her fine work.

Mrs. Domenici. Thank you, Senator, and there are some other

spouses in the audience as well.

Senator WELLSTONE. I would like to recognize all the spouses, be they men or women, and all others who are in this struggle for

truth and justice.

Let me first try to build on what you all have said in your letter, which I think is very important. I will not go into the question that the chairman raised that you have answered, which has to do with how do you measure cost. I think you have done a superb job of that in explaining the cost of people who could be working but are not, the children who could be doing well in school but do not do well, older people who could have more productive lives but do not, people who are in jail who should not be, people who are in the streets who should not be. That should just become crystal-clear to everyone. That is a real cost in both of these areas.

I think that the President and the First Lady recognize this, but I want to go to the question that Senator Metzenbaum raised, because I think it goes right to the crux of it. And I think we owe a real debt of gratitude to the administration, Mr. Chairman, for including mental health and substance abuse as part of the package. At least it is not longer just put in parentheses as if it is not

a part of health care reform.

But I had mentioned earlier the old data and the old ideas that I think really are getting in our way, and I just want to build on the points you have raised and then ask the question, which is that we should be covering both mental health and substance abuse just as we would cover someone who is suffering from heart disease or diabetes. And the real problem with the proposal that we have before us, Mr. Chairman, that I think in the committee we could really improve upon is that we have separate limits on care that is covered inpatient, and that becomes arbitrary, and it becomes discriminatory. There is no reason to treat these illnesses differently.

Second, when it comes to outpatient care—it is much better not to have it focus on institutional care—the 50 percent copay will make it just not affordable for many people. And then the problem will be for what we want to do for institutional care for people who need it, we will not be able to afford it, because the people who should be out in community-based might be essentially forced into

institutional care.

So I really think we have to change this formula because it denies care to people who need it, and it delays care to people who need it, and it is arbitrary, and it is discriminatory. I think we

should be able to fix that.

I also want to mention, since the chairman raised this as well, some figures that are really important. In November of 1993, we held a hearing, and we heard testimony from Hewitt Associates. What they told us, looking at Fortune 500 companies in their experience, is that the cost of a comprehensive benefit—let us take on

the numbers—with flexibility, referring people to the least restrictive setting, which I think all of us agree on—it ought to be delivered in such a way that people can live at home, in the community, in as near normal circumstances as possible, with dignity; I think everybody agrees with that—with the best care, their estimates were far lower than the actuaries at HCFA, who were talking about a much more limited benefit.

HCFA tells us that the cost of mental health and substance abuse combined is \$241 per person limited benefit, with caps on inpatient, 50 percent copay outpatient. Whereas what Hewitt was saying, based upon the experience of businesses with good plans, was that we could do it comprehensive and flexible, covering people

with humane and dignified care, for \$200.

So I think that if we really take new numbers, not numbers that go back to 1982—and I would build on both of your points—that

we are now delivering care in a different way.

Dr. Turnure from Minnesota is going to be talking about that. We really have a tremendous opportunity, I think, in this committee to really come out of this with a very good package of benefits that will work on all counts—humane, dignified, and cost-effective.

This is my question for you all—you will notice that I wanted to say that—but my question for you all is building on your letter—and I do not disagree with you, so I cannot ask those kinds of questions—building on your letter, will you be willing to help us with our committee and help us with other Senators—we have good bipartisan support right now—and help us with members of the House all the way through? I mean, would you be willing to help us one-on-one and continue talking to people, because we have got to break through this, and we are not there yet. I would like to ask each of you whether you would be willing to do that. I know you are busy, and I do not take your time for granted, but we need your help.

Mrs. FORD. I believe so sincerely in this being such an important part of the health reform legislation that of course, I would be willing to be of help in any way I could, whether it be making phone calls, writing letters, making personal contacts, if you think that

can be of service.

Mrs. CARTER. I have worked on this since 1971, and it is so important to me that I will be glad to do anything. I agree with every-

thing you said.

We heard one woman in Charlotte who said in this last interview that if it is a mental condition, it is the same as having a physical condition to that person. So I will be happy to do anything I can to help.

Senator WELLSTONE. Well, I think you have done a lot in being

here today. Thank you.

Thank you, Mr. Chairman. The CHAIRMAN. Senator Coats?

Senator COATS. Thank you both for your testimony.

Mrs. Ford, I think you indicated that the recovery rate, with proper treatment, for alcohol and drug abuse is 65 percent. And I am aware that your clinic in California is probably considered the premier treatment center, or at least one of them.

Mrs. FORD. Well, thank you.

Senator COATS. It certainly is highly reputed. I wonder if you could describe your program there. What does the average individual face in terms of a treatment program, time, cost, et cetera, and what is the recovery rate—was that 65 percent at the Ford Center?

Mrs. FORD. Yes, 65 to 70 percent. Senator COATS. At the Ford Clinic?

Mrs. FORD. Yes.

Senator COATS. And how does that compare with other treatment programs around the country? I would assume it is among the highest.

Mrs. FORD. It is certainly higher than most diseases as far as being treatable. But I am going to ask John Schwarzlos, the president of the Betty Ford Center, to address that if he will. He can give you more details.

Senator COATS. And perhaps you would like John to describe the program, too. I am just curious to know what is involved in providing the treatment necessary to achieve a 65 percent recovery rate.

Mr. Schwarzlos. Thank you, Senator.

Programs like Betty Ford Center that obviously exist around the United States base their program on much of what has been said already today, appropriate levels of care. So that by the time someone comes to a place like Betty Ford Center, most of the time they have had some treatment in an outpatient setting, and that has just not proved to be sufficient to help them recover.

By the time a person comes in, they have pretty much gone through all other resources. They are coming in at a point in their lives where part of what we have to do is much like what Senator Wellstone did, is begin to rebuild that person's very life and their very self-esteem. And you do that with a very structured program.

The normal length of stay at a residential program like ours is

from 20 to 30 days, anywhere in that range. The cost surprises people. The cost at the Betty Ford Center is \$370 a day, which includes everything. It is not a runaway cost or an excessive cost like has often been written about.

During that time, 7 days a week, the person is involved in structured therapy, a lot of 12-step kind of work with other men and

women who are going through the exact same experience.

Then, you build in-and this is what we think accounts for those high recovery rates-very structured follow-up. So for example, if we get a person at the Betty Ford Center from Indianapolis, when they go back there, they are put into very structured follow-up counseling, along with hopefully getting involved in 12-step programs.

So it is a continuum of care that we believe is what makes it work. Whether the person is, again, a plumber, a physician, no matter what occupation or what kind of socioeconomic status, we

believe that kind of structured program can work well.

Senator COATS. Thank you.

Mrs. Carter, I was intrigued by the conference that you and your husband convened in Atlanta with religious leaders on the subject of mental health and other illnesses and societal problems, and listening to their advice on how they could play a role in this. And I was struck by the fact that, as was just indicated, there seems to be a spiritual component to successful programs. The 12-step program is clearly based on spiritual principles, and I think many people would indicate that recovery involves more than just the substance itself—it goes to self-esteem, it goes to self-worth, it goes

to a lot of issues like that.

Our dilemma here is our prohibition against church-State involvement. Many would suggest that if we direct taxpayer funds to church-based recovery programs, religious-based recovery programs, or perhaps any program that involves a spiritual component, that we are mixing church and State, and we run into constitutional problems and we run into political problems even funding that.

I wonder if you could address that question about how important the spiritual component is in successful recovery and how you

might suggest we get around that problem.

Mrs. Carter. I think it is very important. At the Carter Center, we do have an interfaith health program, and we have brought in many people from all over the country, of all different faiths. Our purpose in developing that program was to encourage churches to do more to help their own members in the health care field. So many of our problems are brought on by personal habits—smoking and diet and lack of exercise and those kinds of things. So this program was to help the members of the church, but also, we thought it was one of the best possible ways to reach people in the inner cities with health information and with help.

What we would really like is for every church to assume responsibility for the people in that area, to see that every pregnant woman, for instance, has good prenatal care, and that children have good care, because I think one of the principles of all religions is to outreach, to help those who are less fortunate and those who are in need. The churches know their communities, and it seems to us to be a very special way to help educate people about health problems, but also to help provide some of the service for them.

We did meetings in different cities around the country, and something like 70 percent of the churches have some kind of health program. What better way to help those who have mental illnesses? We hear terrible stories about people who are afraid, who do not like to go to church because people look at them in a strange way, or they do not like to take a sibling or a child who has mental retardation or a mental illness to church because people do not look at them in the right way. Educating people that all people are equal, that people who have mental illnesses are just as much individuals as other people, those are the kinds of things—that kind of spiritual component that when you help somebody, it helps you—those things can make so much difference in our whole health care system, I think.

Senator COATS. I have never forgotten the admonition of a gentleman by the name of Reverend Arnold McKinney from Macedonia Missionary Church of Waycross, GA, who testified before our Children, Youth, and Families Subcommittee in a regional hearing in Macon on the problems of rural youth. He said, "What you in Congress do not seem to understand is that you need to treat the whole person for successful treatment. And the whole person consists of body, mind, soul, and spirit." He said, "You in Government can treat body and mind, but only the church and the family and insti-

tutions outside of Government are equipped to deal with the soul and the spirit. And until you find a way to merge the two, we are not going to successfully deal with the problems that I have to deal with every day—teen pregnancy, substance abuse, child abuse,

spouse abuse, mental health problems, and so on."

I thought that was a great admonition. We do have a dilemma in terms of our prohibitions on merging church and State, but I think it is important that we recognize that if we are going to truly be successful, we have to find a way to treat the whole person, body, mind, soul and spirit.

Mrs. CARTER. We do not have your dilemma at the Carter Center

since we are not governmental.

Senator Coats. I thank you both for your testimony.

The CHAIRMAN. Senator Pell?

Senator PELL. Thank you, Mr. Chairman.

I join in welcoming the two witnesses. They are very nice to give of their time and exploration of their inner thoughts. And I would apologize to Harold Hughes, an old colleague, that I cannot remain

to hear his testimony.

There is one thing that has often puzzled me, and that is, is mental illness more or less or about the same inheritable as is physical illness like heart disease and cancer. Some families have a leaning or a weakness in that direction, and one can see the same disease repeating itself. Is this true with mental illness?

Mrs. Carter. I do not think it is inheritable. I think one of the things that has happened in the past has been that families were blamed when they had a mentally ill person or child in the family. And we have gotten away from that totally with the information about the brain.

Mental illness, like most physical illnesses, I think, comes from some dysfunction in the body, but I would disagree that it is inher-

ited.

Senator PELL. Mrs. Ford?

Mrs. FORD. With alcohol and drug dependency, that is really an unknown fact. It has been stated that perhaps there is a genetic predisposition, but that has never been proven. There has been a lot of research done on the fact that a person is born with a certain difference, actually, in the brain which makes them more apt to lean on a mood-altering drug like alcohol or any other drug.

Senator PELL. Mrs. Ford, what do you think it is that makes someone decide that they should receive treatment? Is it the proximity of a treatment center? Is it something of the spirit that comes

up at a particular time? Is it a family crisis?

Mrs. FORD. Quite often, it can be something that happens in their life, an incident which is catastrophic. In many cases, with women, it can be a divorce or loss of a child or a husband. In many cases, the intervention is done by families who observe the illness in the patient, and yet the illness is so based on denial that the alcoholic himself cannot see it, and the intervention by the family is the method of getting that person to look at the problems and the difference in their reaction to everyday living and be willing to go into treatment.

I sort of doubt that it is the proximity, because you talk about that stigma again, and most people who are going to treatment

very often want to go someplace other than a local treatment center. That makes a problem in some cases as far as outpatient.

Senator PELL. Thank you very much.

Mrs. Carter?

Mrs. Carter. I think the proximity of the treatment is very important in mental health treatment. We are seeing that outpatient and clinical services can be effective, and so it is very important to have services in the community so that people have access to them.

Senator PELL. Thank you very much.

Mrs. FORD. I have to agree with that; I think it is important. And if that stigma were not so strong, people would be more apt to use

Senator Pell. Thank you both very much indeed.

Thank you, Mr. Chairman. The CHAIRMAN. Thank you. Senator Metzenbaum?

Senator METZENBAUM. I just want to express my gratitude. You have done a magnificent job in highlighting this issue, an issue that we are all concerned about. I think every member of this committee is in empathy with the thrust of your concerns, but I am not so sure that we would have zeroed in as you have made it possible for us to do by highlighting the issue. I think that this committee will meet its responsibility and see to it that those who are involved in substance abuse or are mentally ill will be covered far beyond the limits that are provided for, and hopefully equally with all other kinds of illnesses that exist.

I am not going to ask any questions because former Senator Harold Hughes is here, and I am going to have to leave at a reasonable hour, and I want to be certain to hear his testimony. He was one of the most respected members of this body for a period of years, and I just want to be sure that there is enough time left for him

to be heard.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Senator Simon?

Senator SIMON. Thank you.

I just want to join in thanking the two of you. In response to Senator Wellstone's question, I cannot imagine two people who could have more influence on this committee or on the U.S. Senate than Betty Ford and Rosalynn Carter, and I really appreciate your

testimony.

We are spending a lot of time in the Senate these days and in our States, talking about crime. This is not labelled as anti-crime legislation, but in a very real sense, if you are dealing with drugs and alcohol and mental illness, you are dealing also, then, with child abuse and all the other things, so it really is anti-crime legislation.

I do have just one question if you feel comfortable answering it. The time limitations that have been suggested, if I could divide it into alcoholism, the other drugs, and mental illness, in those three areas, does the time limitation that is proposed in the legislation make sense?

Mrs. Ford. Well, in many cases, that time legislation would probably cover the treatment as far as alcohol and substance abuse, but the limitation or the caps on it are very restrictive because there are many cases where there is extended treatment that has to be recommended because people are not ready within the 30 days to go back into society and assume their positions in the workplace and in the social setting. So it should be more adjustable.

Senator SIMON. So that in fact we need greater flexibility. Mrs. FORD. Flexibility. That is the word I wanted to use.

Senator SIMON. For some people, it is fine, but for others, this is just not realistic.

Mrs. FORD. I think flexibility is very important.

Senator SIMON. Mrs. Carter?

Mrs. Carter. I agree with that. I do not think it makes any sense at all, because the needs of people who are suffering from mental illness and substance abuse are different, just like the needs of those suffering from physical illnesses are different. Some might not take the length of time that is allowed; others will need more time. So I think we need flexible benefits so that people get the treatment they need so that they can overcome their problems

with substance abuse and live productive lives.

If you cut off treatment at a certain point, if the treatments are not complete, who knows whether they will be right back in for another round of treatment later, or the next year, or will just lead lives of illness where we have to take care of them by hospitalizing them. I just think that limits do not make any sense at all. And I do not think it will be abused if we have some strict standards for determining the illnesses and some review over the treatment; I just do not think the plan will be abused if the limits are flexible.

Senator SIMON. It seems to me there can be some mechanism. When you have an appendectomy, you can go in and out, but when you have these other kinds of problems, it is more difficult, and there is concern on the part of some that some may be abusing this

and keeping people longer than they should.

Mrs. FORD. If you have complications with an appendectomy,

there is extended coverage.

Senator SIMON. That is a good point. Thank you.

Mrs. CARTER. But I think you could have a review process so that abuse can be routed out. In our poll, that was very important to the people. They were against limits, but they wanted to be sure that there was some review process so that people did not go back and back and back into treatment when it was no longer necessary. I think that can be accomplished.

Senator SIMON. I think so, too. I thank both of you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Wofford?

Senator WOFFORD. I, too, want to thank both of you for your leadership and your testimony today, which I will review with care. And I hope we can keep working with you on this and that as we try to do everything we can do, that this bill will pass in this Congress, and that if we do not do enough on both of these fronts, that we can work together and we come back to this to see the job through.

I would just in passing note that Pennsylvania—and therefore, I assume, some other States—have benefits in at least substance abuse that go beyond what the Health Security Act proposes, and they are proving very cost-effective. I would not want to see anything we do this year let any State fall back from progress that is made. We need to push on, so let us push together.

Thank you.

The CHAIRMAN. I would just like to make an observation and see if you agree. Do you find that people who need mental health assistance and are involved in programs where there are benefits limits delay getting treatment because they know there are limits so their needs get greater? Perhaps they use up all of their outpatient days, and then they have to use their inpatient days, which can be more expensive, so they game the system, which is inappropriate both in terms of treatment cost. Doesn't that sometimes happen?

Mrs. Carter. It happens sometimes that also the coverage for mental health problems is outdated, just as is coverage for physical health, where we cover hospitalization and not the outpatient portion. So people are sometimes hesitant to go, and they have to wait until they can go to the hospital until they will be eligible for payment for treatment for those who do have insurance. And those who do have mental health problems cannot get any insurance anyway. So it is just a real problem all around if we do not provide for them.

The CHAIRMAN. If you could comment on one final area, and that is the needs of children for treatment. In many circumstances, children are left out and left behind, particularly in urban areas and in some rural communities as well. Is this something that both of you are concerned about, that is, whether we are developing a system that will really reach out to children at an early age and respond to their needs?

Mrs. Ford?

Mrs. Ford. Mr. Chairman, I think that is a very important issue because young people today get into trouble with these problems at a very early age, in their teens and sometimes younger. And if they are not able to get some kind of help, this is going to be an ongoing thing. It is going to be chronic, it is going to develop, and it is going to become worse. And the revolving door situation sets up because maybe they get a little help, and they go out, then they have to come in for more help. So if they are diagnosed and treated early with adequate treatment, they will not have that repeating.

The CHAIRMAN. Mrs. Carter?

Mrs. Carter. I think one of the greatest lacks that we have in our system of government is that we do not care for our children. We are working with the Atlanta Project in the inner city, and it is unbelievable what kind of lives children lead today. And we know what to do for children. We know that if they get good care from conception, if they get good health care, if they get good nurturing, and if they get good mind stimulation, that all of these things lead to producing responsible children. When we neglect them, and they live in the conditions that we see every day in Atlanta, they inevitably end up in trouble.

So to take care of our children is one of the most important things I think we can do. We have to find some way to be sure they get good health care as babies, and some kind of care between the time they go to Head Start or to school, some kind of good nurtur-

ing and mind stimulation in that period.

I was in a briefing by someone from the Centers for Disease Control in Atlanta recently, and if children get this good start, it has been found that even their IQs go up. So it is just so important to take care of them and give them good care to overcome some of these problems. I think many of the problems in the inner cities are because we neglect our children.

The CHAIRMAN. I appreciate it. We had a hearing on related subjects the other day in an inner city area where someone who works with youth commented that the children of the country have not

left us, but we have left them.

Mrs. Carter. That is exactly right.

The CHAIRMAN. So I think we have to get back to it.

Are there further questions or comments?

Senator JEFFORDS. Just ending with that one point, I certainly want to agree, and hopefully, we can work together to do some-

thing about the children of this country.

The CHAIRMAN. If there is no further comment, I think you have sensed from the comments of my colleagues here on the committee that we are enormously grateful to both of you. The American people are clearly in your debt for your continued interest and concern, the wealth of information and the thought that you have given to these issues, and your willingness to share that with us to make a difference in the lives of millions of Americans. We cannot express our appreciation strongly enough to both of you, and as you have probably detected, I think we will be calling on you for guidance and insight as this whole process moves forward.

We are very, very grateful to both of you for being here.

We will have a 2-minute recess to allow Mrs. Ford and Mrs. Carter to leave the hearing room. The committee will stand in recess for 2 minutes.

Mrs. CARTER. Thank you for the opportunity.

Mrs. FORD. Thank you, Mr. Chairman.

[Short recess.]

The CHAIRMAN. The committee will come to order.

We have a friend and colleague whom we want to hear from at this time, and then we will hear from a very important panel that will follow.

Our next witness is former Senator Harold Hughes, a pioneer in the field of alcoholism and addictions. His dedication to these issues stems from personal experience with alcoholism and recovery, and while in the U.S. Senate, he was the primary author of Public Law 96-616, the Hughes Bill, which established the National Institute on Alcoholism and Drug Addiction.

He is currently president and chairman of the Society of Americans for Recovery, and chairman of the Harold Hughes Centers, treatment centers affiliated with Des Moines General Hospital in

Iowa.

Speaking from personal experience as a member of this committee when Senator Hughes first entered the Senate and as one who followed his leadership not only in this committee but also in the Senate, I must say that no American has made the difference that Harold Hughes has made. He has both helped shape policy and provided insight into some of the most difficult and painful life ex-

periences of substance abuse addiction and recovery.

He has been an inspiration, for all of us on this committee and in the Senate. He has also been an old friend to me. I have had the good opportunity to travel his State with him and know what a beloved figure he was as a Governor and as a Senator. And he continues to help guide us on some very difficult and challenging substance abuse and recovery issues.

We are enormously grateful to him for being willing to keep at

this issue and to continue to help guide us on these matters.

Harold, we are delighted to have you back here, and we look forward to hearing from you.

STATEMENT OF HON. HAROLD E. HUGHES, FORMER U.S. SENATOR; FOUNDER AND CHAIRMAN, SOCIETY OF AMERICANS FOR RECOVERY; AND CHAIRMAN OF THE BOARD, HAROLD HUGHES CENTERS, INC., DES MOINES, IA

Mr. HUGHES. Mr. Chairman and members of the committee, I am delighted to have this opportunity to appear here this morning. If I seem redundant in any case about what the two First Ladies had to say, their voices were so gentle and so soft that I could not hear many times, sitting behind them, exactly what the responses were. I will not mention the fact that I am a little deaf.

Let me say that this is one of the greatest experiences of my life. As I sat here this morning, I noticed that three of the members of the committee, I have worked for to become President of the United States—I might add none of them succeeded. So if any of you want my support in the future, I think you had better think twice about

it. [Laughter.]

I want to mention a little background of my own experience, Mr. Chairman, with your own family. My first experience in alcohol-related fields was when there was a certain Secretary of the Office of Economic Opportunity whom I went to as Governor of Iowa to seek a grant in the field of alcoholism and addictions for my State of Iowa. We had done a research study that established a direct relationship between the children on Aid to Dependent Children, crimes that were being committed, and men and women who were incarcerated, mothers on welfare and broken families, and we were seeking through the treatment of addiction diseases-which I prefer to refer to them rather than "substance abuse," so if I use that term, I hope the committee will forgive me this morning. The term, "substance abuse," implies that all of us willfully abuse drugs or substances. For some reason, many of us do not have a choice in the matter. There is a lot of addiction disease, and we need to look carefully at the terminology we use.

However, when I first came to the Senate, I was assigned to this particular committee, and I went to the then chairman of this committee, Senator Ralph Yarborough of the State of Texas, and since I was the most junior in seniority on the committee, asked him to establish a new subcommittee which I might be the chair of. As a recovered alcoholic myself, I stated that I was particularly interested in a subcommittee on the diseases of alcoholism and other

chemical dependencies of the time.

The Senator agreed, but he also informed me that Senator Kennedy had jurisdiction over those matters in the health subcommittee, and that there was not going to be any subcommittee of this matter unless I went to the Senator from Massachusetts and pled

my case and got his permission.

As you recall, I asked the chairman, Senator Yarborough, to come with me to see you and discuss the possibility of the establishment of that subcommittee, to which you graciously agreed, and that subcommittee was established, and you agreed to serve on that subcommittee, with so many of the distinguished members of that committee of that day—and there are several who are still

members today, I might add.

So with that sort of background, we did get that grant in the State of Iowa, of over \$1 million, which was a lot of money in those days in a State of medium-sized population. We did set up one of the first treatment centers in relationship to a medical school in the United States. We established a training center for training counselors, for training psychiatrists, for training physicians, for training nurses, for training all the health care disciplines in relationship with chemical disease, because we believed that the books had not even been written yet on the subject matter of diseases of addiction.

As we did that, we did some of the most important things, I think, in establishing a background and a base where we could come in America to some sense of maturity in dealing with addic-

tion disease.

I am an alcoholic. I was born to an alcoholic father. I had no choice in the matter, and my alcoholism came to blossom. I tried to please, and I succeeded in almost every way as an athlete, a musician, and a student. I went into the army at an early age. I fought using a Browning automatic rifle through campaigns in Africa, Sicily, and Italy. When I was discharged from the army in 1945, my alcoholism had blossomed and grown, and for the next 7 years, it grew exceedingly.

In 1948, my first wife tried to have me committed to an insane asylum, as we called them in those days, and brought legal charges against me, believing me hopeless and incapable of managing my

own affairs and ever adjusting to life.

I managed to avoid that commitment. In 1950, I attempted suicide. In 1954, I walked out of the last jail I had been committed to in Kissimmee, FL—which was then just a little backward country town—after a DWI charge, and I have been abstinent now for over 40 years, by the grace of God, and thank God for other men and women like myself who have been very helpful in the process of my own recovery in those early days.

I have known this disease at a pointblank range as well as I have many other things in my own personal life. I have watched my oldest daughter's husband killed in an alcohol-related accident; my only brother was killed in an alcohol-related accident; I have seen other members of my family since my time, generations since then, afflicted with the disease and almost die; and I have watched

the total destruction that comes from this disease.

When I returned to Iowa in 1981 and found that there was a lack of treatment in the State of Iowa for certain specific reasons, we began a treatment center that was gender-specific for women. One of the unseen problems that we uncovered in the treatment of women at that time was the fact that over 65 percent of the women who came into treatment were victims of incest. And when we talk about the dual problems that we are facing when we treat chemical disease in relation to people, whether it is in hospitals, outpatient, or whatever it is, we find a very high percentage of problems that are both uncovered by the treatment of chemical dependency and also those that, if you treat things without treating the chemical dependency, can never be treated well.

I was committed to a psychiatric unit before I was discharged from the army, something I was always ashamed of. Psychiatry and medicine in those days did not know that alcoholism was a disease. They did not know what the problems were. They could do nothing to treat it. They treated everything but the primary cause

of my illness, which was the disease of alcoholism.

I say that I have recovered. Twenty-five years ago, you were present, Mr. Chairman, at the first hearings we held I believe in this very hearing room, when Bill Wilson, one of the co-founders of Alcoholics Anonymous, and Marty Mann, the first lady of alcoholism, who is the founder of the National Council on Alcoholism, both testified. Both of them referred to themselves as "recovered" from the disease of alcoholism. I refer to myself as "recovered" from the disease of alcoholism.

American medicine, or medicine anywhere in the world, has never established a criterion that says when we are recovered. And most alcoholics and addicts who go through life attending meetings, 12-steps groups or whatever it is, refer to themselves as "recovering." The general implication that is then always cast to the public is that we never get well. Nothing could be further from the truth.

We do get well. We get well in numbers that run into the millions. And we remain anonymous. The reason we remain anony-

mous is because of the discrimination against us.

I went back, incidentally, to those same insane asylums—I will refer to them as institutions other than that in the future, but in those days, that is what they were; they were the snakepits of the world—and worked with alcoholics who were then committed to those institutions, and there was no hope for them. But in my commitment to recovery and going back to that, I wanted to see what caused men and women to be abandoned in our society. I made a commitment in my own life that as long as I lived, I would try to do something both to remove the stigma and to bring understanding about the diseases of addiction into my own life, into my own community, into my own State, and into my own country, and hopefully someday, into the world.

We are still battling an awful lot of that stigma. Anonymity is still a main part of the problem that exists with it, because the vast majority of us who have recovered from the diseases of addiction will not speak of our recovery publicly so no one ever knows

whether we got well or not.

A lot of the terminology that we use today implies that we still have the disease, and as a result of that, the implication that we are giving to everyone we talk to is that we are still sick, that we never did get well.

I have approached the American Society of Addiction Medicine, and I have asked them if they will not establish a criterion when someday they will say that this disease is in remission long enough that, like cancer, we can say we have recovered from the disease, because it is difficult for me to appear before this committee today and tell you, Mr. Chairman and the members of this committee, just exactly when somebody got well. We can do that with a lot of diseases. With this particular disease, because the criterion has never been established, we are unable to do that.

We do not even know how to make the diagnosis appropriately in many instances. For example, in my opinion, anyone who is arrested for drunk driving is displaying a classic symptom of the disease of alcoholism. Anyone who has been arrested twice certainly is displaying classic symptoms of the disease of alcoholism. When it comes to the third time, if there is any doubt in anyone's mind

at all, they themselves have a problem.

So we need to look and see what we are doing in our society in order to know what we are doing in diagnosis, in the form of treatments that result and whatever else there is. We need all forms of treatment. And many forms of mental illness are related to and combined with addiction disease. Many of us display many of the symptoms of mental depression and other forms of mental illness, and when the alcoholism or addiction is treated, those symptoms disappear. Yet we do not know how to establish that until the

treatment takes place.

The statistical information which will be referred to later, some of which I have referred to in my own testimony, and that I ask that you incorporate in the record—I wanted to give my own personal background to some extent, the reason why I am primarily here today. I am here as the chairman of the board of the Society of Americans for Recovery, an organization which I founded in late July of 1990. The reason is to try to get the some 20 million Americans who I believe are in one stage of recovery or another from these diseases to stand out in the open, to join a consumers organization, the recovery organization, and to be active politically, so that we ourselves can speak for ourselves in the marketplace and other places in American.

Today, most of the organizations in this field are the professionals of the organizations, who do a great job in everything they do, but they are not the consumers of the treatment, and if they are, they remain anonymous in the process of doing it. So we have

difficulty in being representative in where we are.

I want to express my deep appreciation. I recovered from the disease of alcoholism and other addictions. There are still people up in Ida Grove, IA who are waiting for me to get drunk again, I might add, but that is their problem, not mine. That is a problem of the disease. People never forget the active stages of the disease when we have it, and many of them think we deserve punitive action rather than medical treatment.

Punitive action will not heal this Nation of one of the greatest plagues that is abroad in the Nation today, and that is the victimization of Americans with addiction disease and mental disease

that goes untreated.

I will not go further because I will probably get into a preaching syndrome, which neither you nor I have time for.

Thank you very much, Mr. Chairman and members of the com-

mittee.

[The prepared statement of Mr. Hughes may be found in the ap-

pendix.]

The CHAIRMAN. I was ready to be preached to, Harold; I do not know about the others. I think it is probably something we could

all use a little of.

Let me play devil's advocate for a moment. As you point out, you can be recognized as recovered from appendicitis. It takes a few days, maybe it has a few complications, but it ends. But as you point out, we do not have measurable standards for deciding that someone has recovered from substance abuse or addiction disease.

How do you respond to people who say that since this is a chronic condition, since we have scarce health care resources, and since this is somewhat different from treating illnesses like heart disease and cancer, that it should not be treated the same? In other words, how do you respond to those who say this is open-ended, it will be ongoing and continuing, it will involve relapses, so therefore, it is not the same as other illnesses and therefore setting out some guidelines for cost and cost containment makes sense.

Mr. HUGHES. Mr. Chairman, as far as I know, there is no restriction on treating heart disease for recurrence of heart disease. I have known people who have had six or seven angioplasties; I have known people who have had several open heart surgeries. I have watched some of them who are my friends never change their habits, never change their dietary or drinking habits, who continue to live sedentary lives and invite the recurrence of the disease con-

stantly.

No one blames them when they have to go back to a hospital or they are incapacitated, or they use up hundreds of thousands of dollars of medical funds in that very process of recidivism of a disease that they would have a good shot of some form of recovery if they would in fact change their lifestyles. But as some of them have said to me, "I do not want to change my lifestyle. If I cannot enjoy life, then I do not care about living. I am going to go ahead and drink, eat fat sausage and everything I can, whether I die or not."

That is the same as an alcoholic saying, "I am never going to quit drinking. I am going to go through and get dried out, but after a few months, when I get to feeling good again, I am going to drink

again."

I could give examples like that with other diseases also, Mr. Chairman, in which they single us out. Not all of us get well. I do not want to say that. I would say that probably 20 percent of us never get well and that this is a terminal disease. Many of us die of our disease just as others die of other diseases. Many of us may go for 10 to 15 years and have a relapse and need another cycle of treatment at some point in our lives. Some may go 6 months and have a relapse.

I went 2 years with abstinence and then had a relapse and wound up in jail again. That does not mean that I am a throwaway. When I walked out of that jail again, I knew exactly what

I had to do. I had been in jail in five other States for public drunkenness. I knew what the answer was to me getting well. But I had experimented again with that, and I had failed to live what I knew

I had to live in order to maintain my recovery.

Now, I had had relapses before after shorter periods of abstinence. We are a relapse-prone disease, an addiction disease, but every time we relapse, the vast majority of us gain ground. And if you break the cycle of a disease over which it is not your fault that you have it—we do not willfully decide to be born into a family that has a problem with addictions; we do not willfully decide that we want to go out and lose our lives and our talent and everything that we have, simply because we want to throw it away. It is just not that way, Senators. It just does not happen that way. We are victims of a disease, not seekers of it.

The CHAIRMAN. So if we do not have comprehensive treatment, if we narrow it down and limit it and just do it partway, we will

accelerate relapse as well. Is that what you mean to say?

Mr. Hughes. Well, yes, and the ability to make the appropriate diagnosis, Mr. Chairman, is also important. Right now, for example, I am involved with some treatment centers that we operate. And right now, for example, if a patient comes to us who is a victim of addiction disease and has never been through a cycle of treatment before, usually the first place we have to put that person if they do not need medical detoxification is in the least treatment we can put them in. Now, it may be that, after an evaluation and after medical history, that patient should have gone into inpatient treatment. But we are denied that until we try about three forms of lesser treatment and fail at that, and then we can go to the treatment that the experts would have said we needed in the first place.

The CHAIRMAN. Let me ask you, do you find it a real human and national tragedy when people who are interested in freeing themselves from addiction, cannot get treatment? We know about the long waiting lists for substance abuse treatment that exist in many cities around the country. Isn't it a national tragedy in lost oppor-

tunity, human potential, and other costs?

Mr. Hughes. Mr. Chairman, it is a national tragedy and a lost opportunity. We have already lost a generation of youth. We need to start with the new generation; treat the present generation that is sick, and prepare for those to have relapses in the future. We have filled our jails, and we have stacked our prisons like cord wood, we have glutted our courts, we have filled our mental institutions, and we have overused the capability because this country

is filled with denial about what the problem is.

I am not trying to abolish the substance alcohol, and yet that is what every one of us get blamed for if we want to raise the subject of alcoholism as well as the subject of other addiction disease. All addiction disease, whatever it is, should be placed in one category. We should not separate. Enforcing the law on smoking marijuana is almost impossible. I do not know of a police force in this country today that has a driving edge to go out and stop people from smoking marijuana. They will stop people from selling it or distributing it if they can find it, but not from smoking it.

I do not know of a single person who was ever arrested for driving a car under the influence of marijuana. I am trying to make a distinction here that all addiction disease is addiction disease. Children are misled, and they are misinformed. Our brain is the first thing affected by chemicals we use, and it causes us to commit acts that are against our own will, against our own conscience, against the law, against the morals of society and our own morality. And when we are acting under those influences, Mr. Chairman and members of the committee, we are in a form of insanity that is chemically induced. And once that is removed from us, we become perfectly well, working, constructive, productive citizens of this country.

The CHAIRMAN. Let me just bring up one more subject before my time is up. The "Day One" program on ABC 2 weeks ago did a story alleging that cigarette companies are manipulating nicotine in their cigarettes to ensure they are addictive. The Surgeon General issued a report 10 days ago saying that the major cigarette companies are targeting their advertising on young people, our

teenagers and children.

According to the National Institute on Drug Abuse, 50 percent of all children start smoking by 14 years of age and 85 percent before the age of 19. We have asked for a complete investigation by the GAO within a month into whether these allegations of nicotine manipulation are true. If it is true that the cigarette companies are manipulating nicotine in order to addict kids to cigarettes, that their advertising focuses on children, and that children have difficulty freeing themselves from this addiction, wouldn't you feel that that was a national scandal?

Mr. HUGHES. It would be a national scandal. Cigarette smoking is an addiction disease. We know the results of cigarette smoking. Senator, I smoked cigarettes for 42 years. You may remember I kept the air blue in the back rooms behind this chamber. I have emphysema, and I have late life onset asthma. I carry inhalers in my pocket constantly. I cannot walk over one-third of the pace that I did walk up and down these corridors here; I have to stop and

rest-because of that 42 years of smoking cigarettes.

I hated people who tried to get me to stop smoking. I changed brands. I did everything in the world there was to quit, but I could not quit. It was one of the worst addictions I ever had in my life, and it is a category of addiction disease. And if the evidence is true, as you suggest that it may be, then I think any appropriate action that this committee, this body, and this Congress could take would be well in line with the need of this Nation.

The CHAIRMAN. Thank you very much, Harold.

Senator Jeffords?

Senator JEFFORDS. I think you got the answer you were looking

for, Mr. Chairman.

I want to pursue this line in respect to children and what we can do to try to break the correlation between an alcoholic family and an alcoholic child, especially in those families which become dysfunctional, where the kids really have no parents at all.

First of all, am I right in concluding that an alcoholic family will

produce alcoholics more likely than a nonalcoholic family?

Mr. HUGHES. You are correct, sir. We cannot, as Mrs. Ford indicated, prove with scientific certainty, or beyond reasonable doubt, that this is a genetic disease that goes from generation to generation. I myself believe that it is. One of the reasons we founded NIAAA, as members of this committee well know, was the research arm of NIAAA, so that we can someday find out true answers, whatever they are.

In my family, that has been true. The sons and daughters of alcoholics and the grandsons and grand-daughters of alcoholics, if one on either side of the family has had a problem with the disease of alcoholism, are a target population for alcoholism in this Nation,

and we know that beyond any reasonable doubt.

Senator JEFFORDS. In addition to that, you seem to draw a correlation between sexual abuse of a child in a family and alcoholism;

is that also correct?

Mr. HUGHES. I am not competent nor familiar with the research on that subject matter. Maybe some of the witnesses behind me will have that. If I were to say is there abuse in the family, almost all of the people that we treat have come with some sort of abuse in the family structure; whether it is caused by the disease of alcoholism or not. I have no idea.

Senator JEFFORDS. I guess what I am leading to is is there any way by early intervention, either by mentoring or some other way, to intervene with the children who are in their school or preschool times, that we can try to head off something which seems to be-

Mr. HUGHES. Senator, there are many ways we could intervene through intervention and through education and through prevention. This should be a major thrust in this country. We need to

begin with children who are not even in school yet.

For example, for those who have to take a driver's education course in high school, we do not even teach them the straight facts about drinking and driving. We have a national campaign to have a designated driver if you are going to go out and drink—the other side of that coin implies it is okay to get drunk just as long as you do not drive. It also implies that a teenager at that age has the maturity to go with a car full of other teenagers who are going to be drinking and refuse to drink all night, just so he can drive sober. Now, the odds of that are pretty remote, too, under a lot of circumstances, particularly if the inheritance factor is probable in

So the approaches that we have taken, although well-meant and in some ways very, very helpful-I am not putting them downalso imply other messages to new generations of things that are okay to do. The campaign of "Just Say No"—let me tell you, an al-

coholic cannot just say no; a drug addict cannot just say no.

We can teach and educate children at an early age of good reasons to say no and make a legitimate choice of not using, but if there is a genetic factor in their lives and they ever taste the substance, the probability is they will continue to use. We have to pick up there and provide the treatment, and the treatment education, and the restyling of lifestyle so that that person can get truly well. And that cannot be done in 30 days, Senator.

Senator JEFFORDS. Thank you. I concur with your thinking entirely, and we just have to find and design the ways that we can try to do this, recognizing that it does step in some tender areas when you try to do so. But if we are ever going to end the problems that we have, or at least get them under control, it seems to me

we do have to start at the preschool or earlier time.

Mr. HUGHES. I would predict that if you do something about addiction disease in this country, emphatically, in this Congress or even this Congress and the next one, that by the year 2000 in this country, instead of every State in the Union talking about building new prisons and every county courthouse talking about building new jails or additions to jails, that we could reduce the inmate population of the jails and prisons of this Nation by 30 to 40 percent. Now, people are going to say I am blurry-eyed and a dreamer, but I have seen the results of the effective working of programs that

are effective and that do help people get well.

We have learned a lot. We do know what we are doing. We are not ignorant on this subject matter. Some of the people who have been clinging to the past and methodology of identifying prevention, education, research and treatment believe it cannot be done. For one, I believe it can be done. I believe you should enhance all the research you can, all the latest prevention techniques you can, all the educational techniques you can, and then provide all the treatment you can, and we can reach a stage of average wellness of addiction disease. And also, I might add that mental health will come right along with it; we will reduce a lot of the mental health costs, we will enable better treatment of mental illness in the process of what we are doing.

Senator JEFFORDS. I would just add to your statement that 82 percent of those people incarcerated in our country are school dropouts. That is an incredible figure, and we certainly cannot ignore

it. Thank you very much.

Mr. Hughes. Going back to the Founders of our Nation, they said education was the most important thing for the future of this Nation that existed for all people. And if we have that many of our young people dropping out of high schools as they are in the major cities of this country today, and they then become the victims of addiction disease, we have a future ahead of us that boils down to street warfare, and we need to think very carefully about the decisions we are making right now.

Senator JEFFORDS. Thank you very much. It has been very help-

ful testimony.

The CHAIRMAN. Senator Wellstone?

Senator Wellstone [presiding]. Wow—I do not know where to start. First of all, Senator, I want to mention that when Senator Harkin walked out, he told me he has come down with the stomach flu, so that is why he is not able to be here.

Mr. HUGHES. He sent me a note, Senator, and I was very sympa-

thetic with him. It is hard to sit up there if you have diarrhea.

Senator WELLSTONE. He did not exactly say that to me, but now I understand. [Laughter.]

Mr. HUGHES. He did not say that to me, either.

Senator WELLSTONE. Well, we will have some fun at his expense. Mr. HUGHES. I supported him for President; I am due a liberty here.

Senator WELLSTONE. Senator Jeffords, I was going to mention that a Hennepin County district judge in Minnesota sent me a report, and I think the statistic in the report was that there was a higher correlation between high school dropout and incarceration than between cigarette smoking and lung cancer.

Mr. HUGHES. I am not familiar with that, but I would not be sur-

prised.

Senator Wellstone. It is just a small statistic that tells a very

large story.

I really thank you for being here, and every time I meet with people back in Minnesota who are involved—and I understand what you said; when you said "addictive disease," you taught me something; I think that is the way to talk about it—like people at Hazelton. I think their concern is that there is now becoming such a push on the mental health front—although we are not exactly all the way there yet—they are really worried that there are not going to be people who are speaking out on this other critical, critical area. And I think between Mrs. Ford and yourself and other people who are going to be here, that today is very important.

I just have two quick question, and one of them we have not actually talked about, and it is a touchy one, but I want to talk about it. In your written testimony, you present some compelling data once again that make the case for comprehensive, flexible coverage that is cost-effective. Yet actually, the trend right now is for the insurance companies and some of the managed care plans that are run by the insurance companies to actually cut back on the cov-

erage.

Why, when the data takes us in one direction, do we see such

restrictive coverage by the insurance industry?

Mr. HUGHES. Well, I think it is a matter of being bottom lineoriented, and I think it is a matter of the free enterprise system not being coupled with the medical system, and also not having in the appropriate niches either of managed care or the insurance industry the people who have been professionally trained and educated and skilled enough to make the decisions they are making

about who gets treatment and who does not get treatment.

For example, if you are talking to a skilled nurse 1,000 miles away from your treatment center about whether you can admit a patient or not who is displaying certain symptoms, and they have the ultimate power to say that patient cannot be admitted, when you have an ASAM-certified physician standing right there who wants to admit the patient and says he may die if he is not admitted, then you are risking life by not admitting the patient, and yet you have no power to collect if you do. And those decisions have been with us for the last 5 years now.

Senator WELLSTONE. I will be brief, because I know we have another panel, and I want to make sure everybody has a chance to testify. I was going to ask a question, but I already know what your answer is, about the importance of early treatment as opposed to the consequence of not doing that. And I know you could talk

about that in powerful personal terms—

Mr. Hughes. Early diagnosis and early treatment saves money, saves dollars, saves cents, saves insurance, saves everything, saves lives.

Senator WELLSTONE. OK. We have taken care of that now. But I just want to follow up on what you have just said—and I am a very strong advocate of the single-payer system, but the point I am about to make is not to try to now turn this hearing over to a rally for single-payer—but I do have some concerns about the direction of these huge networks, managed care plans within this managed competition framework, competing to keep costs down. I actually worry about this phenomenon you have just been talking about, because some of the people, both in mental and addictive disorder areas tell me that they have been having huge problems with just what you are talking about, which is somebody on a 1-800 long-distance call, sounding off on treatment before it is covered.

So I think we have to really worry about if the health care delivery is going to become quite consolidated, and you are just going to have a few large networks, many of whom are going to be owned by the insurance industry, and it is bottom line, I am real worried

about where we are going to fit into that.

Mr. HUGHES. Well, the American Society of Addiction Medicine I believe has about 6,000 members in the United States. I have been a member at one time of a health care commission in central Iowa. I sat on that commission, and the first time I went, I looked around at about 20 people on that commission, and in my opinion, not one of the people there was qualified to make a decision concerning addiction disease, yet they were all making them. They had wonderful physicians, wonderful trained people in the insurance business and managed care and everything else, but none of them, not one of them, had a background that would have enabled them to make the appropriate decision professionally that should have been made. And yet that commission was the one that was making all of the determinations about who got or who did not get health care.

Senator WELLSTONE. Thank you.

Senator Durenberger?

Senator DURENBERGER. Thank you, Mr. Chairman. Let me begin by thanking you for your commitment to this cause and for your leadership in this committee. I think all of us are grateful to you for that.

Senator WELLSTONE. Thank you.

Senator DURENBERGER. I will not try to begin to say what I believe Harold Hughes' mission in life is, because he has not figured it out yet, either, but it is just a marvelous opportunity that we all have to have a "Senator (Ret.)," which I think means "Retired," continue to commit his life to public service. It means a lot to me, and our relationship means more than I can ever put a value on. And I think there are thousands and thousands of Americans who can say that, Harold, and compared to what you could do when you held this office, you are so far ahead of the rest of us in terms of your contribution to the people of this country that I am anxious to get out of here and follow your course at the end of this year.

The bottom line, the name of this hearing is "Mental Health and Substance Abuse in Health Care Reform," and the last paragraph in your testimony says, "Universal access to a uniform package of addiction disease benefits equal to those provided for any other

chronic progressive disease is not only excellent public health pol-

icy; it is our only hope for a health care system."

In the other committee in which I sit simultaneously almost every day, the Finance Committee, the chairman, Pat Moynihan, has an addiction for definition. We are all into this lingo of "health care" and "health care reform," and I come to this hearing now knowing whether I am using the right words.

Mr. HUGHES. Nor do I sometimes, Senator.

Senator DURENBERGER. Exactly. So I begin with, I suppose, a definitional question—I sort of begin and end with a definitional question. It tugs at the heart to hear you talk about the people you know who are on their sixth or seventh angioplasty. And yet it is not apples and apples or oranges and oranges in a lot of cases, because nobody should have to be put through that many procedures in an appropriate medical system. And I will not try to make the argument on the other side.

I guess what I am getting at is that it is so easy to say we ought to have the same benefits available when we have not even defined what the benefits are in the other part of this system. So that is our struggle here in the next few months, how do we come to some

kind of a consensus in this area.

I do not argue with you about the treatment issue. I argue with a lot of people about the diagnosis issue. And I should not even use the word "argue." I mean, we have been having these hearings, thanks to the leadership of the chairman and Paul Wellstone and a lot of other people, for a number of years now, and you know, there is a lot of money out there—you talk about too much angioplasty—there is an awful lot of money going into misdiagnosis, inappropriate diagnosis, inappropriate people who should not even be doing the diagnosis of all of this. But that is where you enter into this system.

I will just ask you a personal question if I can. My father is 87, and my mother is 82. I have four sons, 26 to 30. Two of them have been through Hazelton. The number two son would be celebrating if we were celebrating today 10½ years of sobriety. He smokes like a chimney, drinks a lot of coffee, goes to an AA meeting, and people

are either smoking or drinking coffee.

The second son has changed his behavior, but he has not stopped

consuming alcohol. He does not smoke. He does not gamble.

The third son has had his problems, but he is free without treatment.

The fourth, I have a hard time finding an addictive disorder in him, but he loves to gamble. And he is good at it. But that is not

all he does—I mean, he does it recreationally.

The oldest son and his wife are about to have a child, and I am about to be a grandfather. That is a happy occasion. But after I listened to you, I want to know whether or not somebody should not be doing something about somebody in my family. If in fact it is almost 100 percent assured that there are genetic connections in addictive behavior, addictive disorders, at some point in time should somebody be interfacing with my family? Is that what you mean by public health policy? How do we design this system so that it does what we intend it to do?

Mr. HUGHES. The answer to your question is that when you do a medical history of a client who comes in somewhere for treatment, whoever is taking that medical history, whether it is a nurse or a staff person or the doctor, is asking numerous questions, Senator. And they have always asked me whether my father or mother had heart disease; whether my grandfather or grandmother did; whether my father or mother or grandfather had cancer. Not once did they ever ask me about alcoholism.

I have had many times as a man to request to be examined for prostate disorders. No one ever volunteered to do it, although I was paying for examinations and going to the doctors constantly, and in an age group where I am cancer-prone, cancer-threatened, all the time. But they just do not make the evaluation, and they do

not do the examinations.

Women had to fight for years to get breast examinations and to get something done about all that. The answer to your question is yes, in my opinion, is what I am trying to say. My children are just as different as yours. My youngest daughter, to the best of my knowledge, never drank, never smoked, does not eat meat, does not drink coffee. I did everything bad, whatever it was.

I used to say, well, I have an addictive personality, and then the scientists told me there is no such thing. I like to gamble, but I never win; I am not like your son. Thank God, when I sobered up, I quit gambling. When I was drinking, I gambled and lost all the

time because I did not have sense enough to quit.

Yes. The answer is that I do not know, scientifically, what anyone says, but I believe in education as prevention. Every member of a family that has had a problem with alcoholism or drug dependence of any sort needs to have family education and probably family therapy. They need that, and that needs to be one of the goals

that we have.

We disastrously affect about four people around us on the average for every one of us who have the disease, and if there are 20 million of us in this country who have it, which is what I estimate there are, then we have got another 80 million Americans who are affected in the family structure, and we have got about 41 percent of our total national population directly affected by addiction disease. And for the Congress or the people of the United States to ignore that fact is to ignore a blight on America that will consume it given another couple of decades.

Senator DURENBERGER. I just got a note that says my time has

elapsed.

Thank you very much.

Mr. HUGHES. Thank you very much.

Senator Wellstone. Thank you very much, Senator Hughes. We really appreciate your being here today.

Mr. HUGHES. My 5 minutes turned into one whale of a time. I

thoroughly enjoyed it. Thank you very much.

Senator Wellstone. Let me call up our third panel, which includes five experts in the field of addiction disorder and mental health, managed care and benefits analysis. Let me give each and every one of you a short but I hope proper introduction.

Dr. Ronald Geraty is a child and adolescent psychiatrist from Marblehead, MA. He is executive vice president of Medco Behavioral Care in Burlington, MA. Dr. Geraty is also on the faculty of Harvard Medical School and is president of the New England

Council of Child and Adolescent Psychiatry.

Cynthia Turnure—and a special hello to you; thank you very much for being here, Dr. Turnure—has directed the Chemical Dependency Division of the Minnesota Department of Human Services since 1984.

Henrick Harwood has studied the economic effects of alcohol and drug abuse for more than 17 years, most recently as senior manager for Lewin-VHI in Fairfax, VA. Previously, he held several positions in the Office of National Drug Control Policy.

Lenore Behar currently heads the Child and Family Services Branch of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services in the State of North Carolina.

And Edwin Hustead is senior vice president of the Hay/Huggins Company's Washington, DC office in governmental, actuarial and

benefits consulting.

I would first like to thank you all for being here, and I do apologize that the hearing has dragged on. That does not make your testimony any less important. What we will try to do is move along— I may not in fact be able to ask questions, because at about 12:45 or thereabouts, I have to leave for a caucus luncheon. I think the important thing, looking over some of your testimony, is that what you say—and I am not going to rush anybody, but we will stay within time limits—has to be a part of the record. I just want to make that clear. Sometimes when you sit there for a couple of hours and listen to other people, all of which is important, it may seem anticlimactic. Not at all. You all have tremendous expertise, and what we get into the record from this testimony will be a part of this committee, which will be going into markup. So I really appreciate you being here, and I know I am speaking for the chairman as well.

Dr. Geraty, we will start with you. Thank you.

STATEMENTS OF DR. RONALD GERATY, EXECUTIVE VICE PRESIDENT, MEDCO BEHAVIORAL CARE, BURLINGTON, MA; CYNTHIA TURNURE, EXECUTIVE DIRECTOR, DEPARTMENT OF HUMAN SERVICES, CHEMICAL DEPENDENCY PROGRAM DIVISION, STATE OF MINNESOTA, ST. PAUL, MN; HENRICK J. HARWOOD, SENOR MANAGER, LEWIN-VHI, INC., FAIRFAX, VA; LENORE BEHAR, HEAD, CHILD AND FAMILY SERVICE BRANCH, NORTH CAROLINA DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, DEPARTMENT OF HUMAN RESOURCES, STATE OF NORTH CAROLINA, RALEIGH, NC; AND EDWIN C. HUSTEAD, SENIOR VICE PRESIDENT, HAY/HUGGINS COMPANY, WASH-INGTON, DC

Dr. GERATY. Thank you very much, Mr. Chairman.

Thank you for conducting this hearing and for highlighting the need for treatment of those patients who suffer from psychiatric

and chemical dependency illnesses.

My name is Ronald Geraty. I am a child and adolescent psychiatrist and am currently executive vice president of the largest managed behavioral health care corporation in the United States. In that capacity, I have spent the last several years planning efficient behavioral treatment programs for insurance companies, HMOs,

PPOs, employers, and unions.

It is from that perspective that I have arrived at the conclusions that 1) treatment of mental illness and chemical dependency has been demonstrated to be clinically effective and cost-effective and is a necessary component of any comprehensive health care benefit package; 2) the goals of improved access, demonstrated quality and cost-effectiveness have been illustrated only in a managed care environment; and 3) equivalent benefits for behavioral health are affordable now.

Dramatic new evidence just released last month demonstrates that psychiatric and chemical dependency treatment is affordable in both the employed and Medicaid populations. These studies are important because they cover large populations, and especially because these are not analyses, projects, or actuarial studies. These

studies report actual experience.

Each of these studies was conducted in a managed behavioral health care environment and demonstrate greater access, lower

cost, and demonstrated quality.

The American Managed Behavioral Health Care Association, AMBHA, is an organization formed by the largest 15 managed behavioral health care companies in the U.S. AMBHA commissioned Milliman and Robertson, one of the country's leading actuarial consulting firms, to study the cost of providing treatment with the benefits as proposed in the Health Security Act. With those benefits, in an employed population covering 35 million lives, the actual cost of providing the treatment was \$139 per person per year in a managed indemnity plan, equivalent to the high-option benefit in the HSA plan; \$75 in a point-of-service PPO plan, equivalent to the blended option in the HSA plan; and \$42 per person in an HMO, equivalent to the low-option plan in the Health Security Act.

These results contrast sharply with earlier estimates from HCFA and other analyses, and yet it is important to realize that this information was not available to HCFA in their analysis. It is also important to remember that this compares to HCFA's analysis in an employed population, which was \$141, so this information is relatively consistent except they did not have the advantage of the

other kinds of options that are now currently in existence.

Of course, this study was conducted on an employed population. But last month, Brandeis University released a study it had conducted on the Massachusetts Medicaid program where First Mental Health, a managed behavioral care company, managed the care of all Medicaid recipients in the first statewide managed mental health program in the country. Brandeis reported that an annual trend of increases was dramatically reversed, and at the same time, access was improved and quality demonstrated.

In the Brandeis study covering 1993, costs were decreased by 22 percent, saving the Medicaid program \$50 million, and more patients were treated in more programs, and again quality was dem-

onstrated.

I wish I had the demonstration of that, but technology failed me, so it is in the testimony. Remember, both of these studies are not

actuarial studies or projections. These are reports of actual experience.

We are confused when we hear people claiming that mental health costs are uncontrollable and that effectiveness cannot be demonstrated. In analyzing the rate of increase in cost, in our experience, increases have occurred only in the indemnity area. Once again from the AMBHA study, in the last 2 years, although costs have increased by 9.5 percent per year in the indemnity area, increases have been held to one percent per year in the well-managed environment. That is much less than the current annual increase in the CPI.

Addressing our ability to manage cost with benefits equivalent to the medical/surgical benefits, Milliman and Robertson reanalyzed our experience and found that we can afford equivalent mental health benefits now. Although the costs of these equivalent benefits would increase dramatically in an indemnity, fee-for-service environment, costs would increase only minimally in the well-managed environment. So why not allow these equivalent benefits now?

It is important to realize that these are the costs in a relatively unlimited benefit package, the same benefit package that applies

to the medical/surgical area.

Two important studies are now in process and will be completed within 30 days. AMBHA will be reporting on measurements of quality and access, covering 65 million lives. And although this report will be an aggregate of several different methods of measurement, next year, all of our companies are committing to collect the information consistently so that quality can be measured and reported on in a consistent fashion. We believe this demonstrates our

commitment to measuring quality.

The second study currently being done is again being done by Milliman and Robertson, for the managed behavioral care companies and the National Association of State Mental Health Program Directors, in which we will report on the costs of care for not only the employed population, but the seriously and persistently mentally ill, the unemployed, and the Medicaid populations on a national basis. We believe this report will lead us all to the conclusion that to provide truly effective care, we need to integrate the public and private delivery systems.

Finally, let me say that if managed behavioral health care companies with individualized case management and demonstrated quality and access are the only approach that has demonstrated cost-effectiveness, why not require that treatment costs, quality and access, be measured and managed by psychiatric professionals in a managed care program, rather than by setting arbitrary bene-

fit limits for patients who deserve full treatment?

Thank you very much.

The prepared statement of Dr. Geraty may be found in the ap-

pendix.]

Senator WELLSTONE. Thank you very much, and I know that Dr. Turnure is in part going to talk about the integration of the public and private from the Minnesota viewpoint.

Dr. Turnure?

Ms. TURNURE. Thank you, Senator Wellstone. It is a pleasure to be here.

What I would like to do today is describe briefly the Consolidated Chemical Dependency Treatment Fund, which has been operational on a statewide basis in Minnesota since 1988, and then discuss the implications of our data and experience for providing cost-effective substance abuse services under health care reform.

Table 1 in the handout provides an overview of the Consolidated

Fund, and Table 2, its original policy objectives.

The Consolidated Fund combined treatment dollars from a variety of separate funding sources—Medicaid, general assistance medical care, our State hospitals, the alcohol and drug abuse Federal block grant, general assistance, and some State treatment dollars, each of which had their own eligibility, local match, and vendor criteria, into one fund that allows the dollar to follow the client to the most appropriate, cost-effective program that can meet the client's needs.

Funds are allocated to 87 counties and 11 Indian reservations on a needs-based formula. Clients are assessed and placed at the local level according to statewide criteria which are administered independently of treatment providers. The levels of care covered are primary inpatient treatment, primary outpatient treatment, half-way houses, and extended care. All providers in the State of Minnesota now compete for the public clients, and we really no longer have a two-tiered system of treatment in Minnesota.

The Consolidated Fund has been successful in meeting its goals. We are treating one-third more clients than treated under the previous systems—approximately 20,000 a year. The cost of treatment has increased less than 7 percent between 1989 and 1992, versus 28 percent for other medical costs during the same time period.

This is shown in Table 4.

We are saving an estimated \$10 million a year due primarily to a 10 percent increase in the use of outpatient treatment, shown in Table 5, as appropriate. It should be noted that we still place about 30 percent of the clients into residential care if that is what they need.

Counties have also been successful at negotiating good rates for our public clients, about 10 to 20 percent less than others pay,

since they can guarantee volume.

And client outcomes are excellent. As shown in Table 6, almost 60 percent of our clients are abstinent 6 months after treatment, and there are significant reductions in arrests and medical costs. In fact, 80 percent of the cost of treatment is offset within 1 year due to reductions in medical and psychiatric hospitalizations, detox admissions, and arrests, as shown in Table 7.

What are the implications of our data for how substance abuse should be covered in health care reform? Table 8 summarizes what we have learned. I would like to emphasize three of these points

in closing.

One, the best way to control the costs, both short and long-term costs, of this illness is to provide flexible, individualized coverage that is based on standard assessment criteria. The proper matching of clients to the most cost-effective programs that can meet their needs is where you will achieve the greatest savings, not by imposing artificial caps or limits.

No. 2, quality assurance and accountability should be built into the new system from the beginning. We have excellent models already in use to assess and place clients, to measure treatment outcomes, and to license programs and counselors. We do not need to

start from scratch in these areas.

Three, as we move toward a one-tiered system for both the public and private client, we must plan the transition carefully so that people do not fall through the cracks and then find there is no safety net. There must be adequate funding for the supplemental services needed by some clients, as well as services for those who exhaust their basic benefit, if benefits are limited in some way. And there must be flexibility for States in designing the new system to complement what they already have in place.

Thank you for this opportunity to present our findings. I would

be glad to respond to questions.

[The prepared statement of Ms. Turnure may be found in the appendix.]

Senator Wellstone. Thank you very much.

Mr. Harwood?

Mr. HARWOOD. Good morning, Senator Wellstone. Thank you for

the opportunity to address the committee today.

My name is Rick Harwood, and I am a senior manager with Lewin-VHI, a Washington, DC-based health policy firm. I am, however, speaking to you as a private citizen today and not on behalf of the corporation.

I want to start by stating that I do strongly support the concept of having comprehensive benefits for substance abuse treatment. I have not worked on the mental health side recently, but for sub-

stance abuse, I strongly support that concept.

Let me turn that around and State that I would like the committee to consider that a bad benefit for substance abuse treatment incorporated in the legislation could be worse than no benefit whatsoever. I think it is very important to think about what is put into the legislation, because if there is a major effort put into incorporating a limited benefit into legislation, it may come at the cost of support for other kinds of services and other kinds of funding for substance abuse treatment that the public system currently provides, through the block grant and categorical funding and other purposes.

I am really going to speak primarily on the findings of a study that I have done, trying to estimate at the national level how much we are spending on substance abuse treatment. Therefore, I am not talking about a particular plan on a particular population for John Deere employees, for example, or Metropolitan Life, or any other. What I have tried to do is estimate what we are spending on sub-

stance abuse services in the United States.

By my best estimate, it looks like our Nation in 1993 was spending about \$7 billion a year on substance abuse treatment, which was about \$25 per man, woman, and child in the United States.

I tried to divide that out by the sources of payment, and here I am going to pick up on a theme that has been mentioned by the two prior speakers, that is, that there seems to be a private system and public system. I have tried to divide the expenditures and the source of funding from these two, and what I found was that it

looks like the public system-meaning the block grant at the Federal level, State appropriations, and so forth-was providing about \$4.3 billion out of this, and that private insurance was paying about \$1.6 billion of it.

If you look at the privately insured population in the United States, this leads to an estimate that private insurance companies are spending about \$10 per person per year on private insurance, just about \$10 per person per year. That is fairly limited.

In contrast, if you focus primarily on those 100 million individuals who have no insurance or who are beneficiaries of Medicaid or Medicare, it looks like expenditures are about \$45 per person per year. And this kind of disparity between the privately insured

and the publicly insured population has been noted before.

I want to point out that these numbers, though, reflect a very grave weakness, that is, the weakness of the disconnect between the private system and the public system. The private system, primarily having very limited benefits, requires that individuals who need treatment for severe problems and chronic problems are going to resort to the public system to get their care. That is a finding of my study. It looks to me, conservatively, like about 20 percent of those people who are getting treated in the public system may have private insurance, but they have already exhausted that benefit.

If you turn it around and you ask about how much care those who have private insurance are getting, it looks like about 30 percent of the care that people with private insurance in the United States are receiving, 30 percent of the substance abuse care, is being paid for by the public system. This is the disconnect that we have between a private system with limited benefits and a public system that attempts to help as many people as it can. The safety net does catch those with no insurance as well as those people who exhaust their insurance benefits, the limited benefits.

This is what we are facing when we try to write laws and make mandates about what these insurance benefits should be, and this is why I do want to reiterate my conclusion, that I think a limited bad benefit, if it comes at the cost of support for the public safety

net, could be worse than no benefit whatsoever.

I will leave it at that. Thank you very much for the opportunity

to speak, Senator.

Senator Wellstone. Thank you. I think your last point is very important—very important. It is one of the things that some of us really fear.

[The prepared statement of Mr. Harwood may be found in the

appendix.]

Senator Wellstone, Dr. Behar?

Ms. BEHAR. I am Lenore Behar. I have managed the Child and Adolescent Mental Health System in North Carolina for 23 years now and am primarily a public sector advocate employee. But I have been asked to speak today about one demonstration program that we have run in the State of North Carolina, exclusively for children and adolescents with mental health and substance abuse problems.

This is a program that we have done jointly with the Department of the Army at Fort Bragg, NC, where there are now 46,000 chil-

dren who are eligible for the services of this project.

When we began planning this project in 1986-87, our goal was to impact on CHAMPUS as a publicly-funded insurer of military families to help them understand the importance of broadening the benefit to make it more flexible for children and adolescents. The goal was not only to impact on CHAMPUS, but the other insurers and the public sector decisionmakers, namely, the State legislators and Federal decisionmakers as well.

We did not know then what we know today, which is that this project has led rather nicely into information for health care reform. Our goals were a little more modest at that point, but I think we have established some very important benchmarks along the

way.

What we have done is designed a totally flexible system. There is no limit on benefits, there is no limit on the types of services or the amount of service to be provided. There is no copayment, there is no deductible for the families. Any family who has a child with a mental health or substance abuse problem comes through the doors of a special clinic that has been set up for this purpose. So

it as unlimited a benefit as one can imagine.

And what do we find from this? We find that in a comprehensive delivery system where multiple kinds of services are available, where the family is an important part of the design of the treatment program, where there is flexibility, that despite all of this open-endedness, we have seen a dramatic decrease in the use of the restrictive services, hospital and residential treatment center services, and an increase in the family-based, community-based

services on the outpatient and day treatment levels.

We have also seen a rather dramatic shift in funding, that 27 percent of the dollars spent are going for inpatient and residential treatment at the Fort Bragg project, and 84 percent are going for those types of services at the two comparison sites of Fort Campbell and Fort Stewart. And to use your comment earlier, Senator Wellstone, they used the 1-800 managed care approach, but 84 percent of their dollars and 10 percent of the children being served are going into restrictive services whereas in the project at Fort Bragg, only 4 percent are using the services, and only 27 percent of the dollars are going in that direction, because there are other services available, and because—and I think this is a very important point that maybe has not been made earlier—intensive in-home services and intensive emergency crisis stabilization services are used rather than hospitalizing immediately when it looks like a major crisis in the family.

The evaluation data are being provided by Vanderbilt University Institute for Public Policy, that is studying both the demonstration

site and the two comparison sites.

The other point that I would like to make is one that we have been hearing and speculating about, I think, all morning, and that is the cost per child served goes way down. As I was listening to your comments earlier about the cost of a mental health or a substance abuse benefit, I began to be troubled, and if I may speak a little extemporaneously, one of the things that we have found is

that the use of the benefit shifts; that there is a decrease in use of pediatric services, a decrease in the use of family practice services. And Colonel Febo, who is here from the Surgeon General's Office of the Army confirmed for me today that there is also a decrease in use of adult mental health benefits if services are provided to the children.

Now, this is not to say we ought to have a mental health benefit or a substance abuse benefit for children and not look at those other benefits, but it is to point out that there is a dynamic effect going on, that we cannot look at a fixed amount for each of the disabilities or medical problems or whatever, and that costs and the use of services shift, depending on what is available. I think that that is very important to keep in mind.

Families will search for help for themselves and their children. If they cannot get the appropriate help in a mental health or substance abuse program, they will get it somewhere else, so the costs will go up there. And I do not know how we are going to deal with

that, but I think that we cannot pitch and hold these costs.

So to summarize, we have established a program with a more flexible benefit, a wider array of services, and we have been able to shift the use of services and the use of some restrictive services

into the family and into the community.

The final evaluation data, the outcome data, are not available at this point, but I would say that the Army has decided to extend this program for another 4 years, so they think it is valuable. And we are using the same model in a Medicaid waiver program in North Carolina.

I would like to end by complimenting the Department of the Army for their foresight in supporting this program. It has been the mental health professionals and the other medical professionals who have seen the value of this, and the families themselves, because they have recognized that stress on the job is very high in the kind of work these people do, and to add to it the family stress of children with problems makes performance questionable. They have known what employers have known for a long time, and that is that performance on the job is related to family comfort.

Thank you.

[The prepared statement of Ms. Behar may be found in the ap-

pendix.]

Senator Wellstone. Thank you very much. I too would like to congratulate the Department of the Army for really leading the way. I think the Department has lit a candle here. And I just have to say to you all again that it is so important for us to have these concrete models and this concrete data as a part of the record, because ultimately, it is going to be so—no matter how much we talk about what the right thing is to do, we also have to be able to meet all the objections about cost, and we have to be able to talk about that in fact this is cost-effective. We have to win that argument and that debate, and I think we can, and I think your testimony is extremely helpful.

Mr. Hustead?

Mr. HUSTEAD. Thank you, Senator.

My name is Edwin Hustead, and I am with the Hay Group, Hay/ Huggins Division, the actuarial branch. Among our other work, we work closely with Congressional Research Service and provide input to their data in the analysis of

national health care reform proposals.

To briefly reiterate what has been said on the private sector and what is there now, the large majority of plans in the private sector place absolute limits on both inpatient and outpatient treatment; they give very little thought to these limits; they impose them and leave those benefits alone at that basis. When an individual hits those limits—commonly, 30 days inpatient, up to \$1,000 or \$1,500 outpatient, which does not begin to pay much of the bill on the outpatient basis—they are left on their own devices and either have financial restrictions or cannot afford the care.

One aspect of it that is very important is that there is a diametrically opposed treatment of mental illness and nonmental illness. On nonmental illness, employers have seen the need to cap an employee's out-of-pocket expenditures at \$500 to \$2,000. On mental illness, those benefits are never under the cap; instead, the individ-

uals are left entirely on their own.

One of the reasons that employers and insurers have taken this approach is because of a fear of the unknown, a lack of information. And if nothing else has happened in the last 6 or 7 months in the debate on the HCFA numbers, a good deal of actuarial knowledge and information and databases have come together. Numbers that have been used already this morning show that there is quite a bit of consistency on what actuaries see the cost of the current private sector benefits are. HCFA uses a number of \$141 in their estimate. Dr. Geraty referred to a \$139 figure that Milliman and Robertson use. There was a reference earlier to a number of \$143 that the Hewitt Associates brought before Congress late last year. And that \$140 number is close to the one we have.

We look forward, as I know most of the people in this area do, to the results of a group of the Academy of Actuaries which includes representatives from all aspects of our profession as well as outside. It includes the actuary that worked on Dr. Geraty's study, for instance. Sometime in the next 2 or 3 weeks, they will bring to us and to Congress information on all of their views of what this cost is, as well as the costs of both the current system and the fu-

ture proposals, such as the Health Security Act.

With that information in hand, the information such as presented today, we should be able to build models that accurately measure the cost and can move the debate beyond the numbers and into the design of the benefits packages.

Thank you.

[The prepared statement of Mr. Hustead may be found in the appendix.]

Senator WELLSTONE. Thank you very much.

Senator Jeffords, I had mentioned earlier to the panelists that I will have to leave now. Do you have any questions?

Senator JEFFORDS. I would be glad to take the hearing over; that

is no problem at all.

Senator WELLSTONE. Thank you very much.

Senator JEFFORDS [presiding]. I want to thank you all. One of the reasons I had to duck out was that I had my representatives from

my psychological families in Vermont down, worried about what we are doing down here, as I think probably everybody ought to be.

I have some questions that I can complete in a relatively short time before I have to go. First of all, with Senator Hughes, we talked a little bit about early intervention, and I wonder if you could tell me from your experience, whether, first it is really something we should be doing, and if you know, whether it is being done in any area of the country that you are aware of to any great extent—and that is early intervention with preschool and school children to identify potential problems and to try to solve them.

Yes, Ms. Behar?

Ms. Behar. As the child person on the panel—I guess Ron is, also—I can point out that there are a number of initiatives, some of them nationwide, some of them in specific States. Public Law 99-457 requires that States provide services for children zero to 5, preschool children, who have handicapping conditions.

In many States, the issue of children with mental health problems or children who may be headed for substance abuse problems is clearly being ignored. But in some States, North Carolina being one, children with atypical development who seem to be at risk for

those problems have been identified.

The advantage at that age is not so much to provide treatment, because prevention in the zero to 5 age group in a sense addresses many later problems of childhood and adolescents. The same kinds of prevention strategies that we think work in preventing substance abuse and mental health problems also impact on school dropouts, teenage pregnancies, and other kinds of social problems, and what is really being focused on is helping families to understand, first of all, how to raise children; second, helping children understand how to deal with stress; and third, helping children understand how to access help when they need it.

Now, that carries over into the school-age children as well, but if we are talking just about the little ones, there is an opportunity to do even more through early identification programs, Public Law

99-457 being one of them.

North Carolina also has an initiative through the Governor, as other States do; it is called Smart Start. Head Start is another example of those kinds of programs. If we could build more focus on "psychosocial"—to use their term—aspects of prevention into those programs, I think we could go a long way.

Senator JEFFORDS. Anyone else?

Dr. Geraty?

Dr. GERATY. Senator Jeffords, thank you very much for asking that question because I think, as I have looked at the various health care plans that have been proposed, there has been very little attention paid to the important need of prevention as a part of the health care system. So especially in the area of child and adolescent, especially in the area of psychiatry, although unfortunately we do not have definitive evidence as some of the other things we have presented to you today, there is very strong anecdotal evidence and very strong belief that early intervention will have a major impact not only on the mental health of our population but a number of the other areas that you were talking about earlier in regard to the penal system and the general health care system.

Senator JEFFORDS. I appreciate that, and if any of you have any studies that you know of or are aware of, if you could let me know about them, because I am deeply interested in trying to use education to help solve some of the problems. We talk about crime and so on—you heard the evidence earlier that 82 percent of our people who are incarcerated are school dropouts—and yet we have done little to focus on the education side. We are talking about the Goals 2000, and if you take a look at the goals, you wonder where the resources are going to come from. I feel very dedicated as the ranking member on the education subcommittee to bring that question up, and we did last Friday before the Budget Committee, saying, okay, we are telling the country that we have got to solve all of these problems, and then we are just going to throw it back to the States and local governments and say here are the goals, now go to it. Then you look at the resources problems they are having we had all sorts of school budgets turned down this past town meeting day in Vermont and all over the country. So I appreciate

Second, the parity between the physical and mental health has always been a very divided issue on the benefit packages. But I think that also reflects perhaps the overutilization of the physical side as being the credible evidence on what the benefits ought to be, rather than the mental side. Is that part of the problem, or why do we end up with that disparity when you have the broad population saying my God, we need more mental health care, and if you heard all the statistics, you would wonder how this developed. Is it a bottom line situation of fear, or what do we have to do as far

as a health care plan, if there is a problem in that respect?

Ms. TURNURE. If I might respond, Senator, I think some of the factors that have already been mentioned today in terms of stigma and misunderstanding of these particular diseases are part of the problem. I think that our fields have been held to a level of accountability that is much beyond what other illnesses have been asked to provide. In fact, we do have the data to answer the questions, and we probably have more than in many other areas of physical illness. So I think it still is a lack of understanding, and also taking a short-term view, which has been a problem when an insurance company or even an HMO may only have a covered population, say, for a limited amount of time. They are not so concerned about the long-term cost; they figure someone else is going to pay for that, or maybe the public sector.

So I think some of the limitations—they say, oh, just provide the cheapest treatment, and then if they need more, they will not be

ours anymore, and we will not have to worry about it.

Now, if we have universal coverage and a one-tier system, I do not think people will be able to do that anymore. As in the public sector, they will have to look at the long-term, as our counties do, and realize that if they do not treat people right the first time, they are going to come back again, and they are going to have to pay for it again.

So I think if we have universal coverage, and people cannot kick people out after a year and say, oh, let someone else have that contract, that we will see some changes in terms of looking not just at the bottom line that year, but the bottom line in 10 years, to all of the people they have to provide coverage to.

Senator JEFFORDS. Mr. Harwood?

Mr. Harwood. Senator, if I might, I would like to elaborate on that last point about the short term versus the long-term. I think you also have to look at it as to whose pocket the moneys are coming out of in terms of the consequences of substance abuse or mental health.

If you look at it from the very narrow actuarial perspective of the health insurance plan, you think only about utilization of health care. You may think about additional admissions for mental health and for substance abuse. If they are thinking ahead, they may think about the consequences of liver sclerosis and of other kinds of diseases that happen after some more extended period of time.

But quite frankly, even the sharpest pencil actuary working for a health insurance plan is going to miss the main reasons why we care about treatment for alcohol abuse and drug abuse, and that is not the narrowly defined health consequences of alcohol and

drug problems.

This committee today, at least in the sections that I have heard, has not talked significantly about crime, and it has not talked about dependency on the welfare system, but in fact alcohol and drug abuse are major causes of the crime problems that we have in this Nation, and they are certainly involved with the number of people being dependent on the welfare system in the United States.

The actuaries, who are doing a very honest and very forthright job in looking at the value of the benefit and the contribution of the benefit for alcohol and drug abuse treatment, do not include the benefits that would accrue from effective treatment of alcoholics and people who are abusing drugs. And that economic reality I think has driven the public sector to invest more in treatment for substance abuse than has been true for private insurance plans. And I think that is a reality that you cannot forget when we are talking about reforming health care financing.

Senator JEFFORDS. If we go to a situation with capitated payments, I am concerned about the ability to be able to get integrated systems with respect to mental health, or to totally integrate the physical and mental health, because of competition among the limited dollars. Do you think it is reasonable to expect that we can get the residential care and the other mental health systems to be able

to work together and figure out how to divide up that pie?

Dr. GERATY. Speaking for companies that handle capitation as a regular course of business, I think you can not only expect it, but you should demand it.

Senator JEFFORDS. I was hoping that was going to be your an-

swer.

Dr. GERATY. I think one of the great things about our system is that it has encouraged innovation—by "our" system, I mean our country's system. And as there was a move toward carved-out programs, at the same time now, currently, you see a move toward carved-in programs in which there is not the disintegration of the system, but actually the expectation that med/surg systems and the mental health and chemical dependency delivery system is an inte-

grated delivery system, and in fact, all of those levels of care and professionals are available to participate in the treatment process.

And one of the things that we are most interested in being heard, too, is it is not so much the issue of least restrictive treatment; the most important thing is most appropriate treatment. So the concept is not so much restriction as it is let us get the most appropriate treatment by the most appropriate professional, at the most appropriate level.

Senator JEFFORDS. Any other comments?

Ms. TURNURE. One final comment on how to make sure that that does happen is to again make sure that there are criteria, that those criteria that are public that are being used by whomever is managing these various benefits, that the people making the decisions have some training in the particular field that they are doing the referrals for. It is fairly simple.

Senator JEFFORDS. Dr. Behar?

Ms. Behar. I think in the past, we have seen an awful lot of costshifting. I think that is what some of us are talking about. You can shift costs from health to welfare and from welfare to education in some cases—I am talking about children particularly—getting different systems to pay for the needs of the children. There needs to

be a way of coordinating all of that.

Sometimes we at the State level feel that we are the last payer, that after everything else has been exhausted, State dollars are used. But it is public money. There is Federal money and State money, and the Federal money is in a lot of different pots. We have seen it with CHAMPUS as some of the costs have shifted to Medicaid. It seems to go round and round. Somebody has got to get a handle on this great, big pot of money that is going to be distributed and try to understand how it is being used, because there are wonderful ways to game the system.

I can tell you what is going now, but we cannot predict for the future. If we could, we would control it. But that is what is going to happen if some group of people does not get control of it all.

Senator JEFFORDS. Mr. Hustead?

Mr. HUSTEAD. Senator, as an actuary with a sharp pencil, to draw together the last two questions, the reason why the arbitrary limits are in there historically is tradition—I mean the actuarial profession, the insurance industry. Years ago, I asked people, Why do you use \$50 a visit and 20 visits outpatient, and they said it was because somebody wrote that on the walls before they left years ago, and they have always used it.

On the other hand, there is a reason for that, and that is that there was a concern about mental illness, a stigma to it, but also an uncertainty about what the treatment was and how it could be

used and allocated.

I think the professions that deliver mental health care have come a long way, as you have heard this morning, in realizing that there is not an unlimited pool of money; there is a pot of money, and there needs to be a way to figure out how to split that out and make it effective for people. I think the actuarial profession now needs to come along and is over the last year coming to the realization that a well-designed package can be as easily calculated and

administered as in nonmental illness. Again, the Academy of Actuaries' report in the next few weeks should demonstrate that.

Senator JEFFORDS. Let me just leave you with a final comment. We suffer in Congress, I think, from the same problem insurance companies do in that regard. We do not get credit for the savings of the future in the present, so when we are working on our budgets, we cannot think in terms of the fact that 4 or 5 years from now, the number of welfare recipients is going to go down substantially, and therefore the welfare budget is going to go down. The welfare budget may be in another committee, besides. So we always think in terms of how can we save money between now and the next budget cycle, which is a hard thing that we have to fight, but I am hopeful that we can begin to get ourselves to be able to accept the risk of doing some future planning that will result in future savings and reorder our priorities in order to do that.

That is one thing I am working on right now, trying to get us to reorder our priorities in education and say, look, the budget is one thing, but if your ship is sinking, it is a better idea to plug the hole now, and you will be a lot better off in the not too distant future if you plug the hole. It is hard to get people here to think that

way, but we are giving it whirl.

I want to thank you all for very excellent testimony. I look forward to working with you, and I will reserve the right, as long as I have the gavel here, to say that members may submit questions to you over the next couple of weeks, and hopefully you will be willing to answer those in writing.

[The appendix follows.]

#### APPENDIX

#### PREPARED STATEMENT OF ROSALYNN CARTER

I would like to begin by thanking Senator Kennedy and the other members of the

committee for the opportunity to speak here today.

Senator Wellstone, I guess I am finally honoring my earlier promise to you and would like to thank you for your original invitation and for your patience.

Many of you know that I have had a long-standing interest in the area of mental health and in the needs of people with mental illness. Betty Ford, as you also know, has had a long-standing interest in the needs of people with addictive disease. When Betty and I talked several weeks ago, it was clear that we were both becoming more and more concerned about what was happening to mental health and addiction benefits in the various health care reform proposals.

We decided to work together to see if we could do something to increase public awareness about the scope of the mental illness and addiction problems in our country and to convince people of the golden opportunity presented by health care reform to take a significant step in the direction of providing better and more cost effective

treatment for these disorders.

The significant step would be an adequate benefit for mental illnesses and addictions in any health care reform adopted by the Congress. Our ultimate goal is that mental illnesses and addictions be treated on a par with the various physical illnesses in health care reform.

The survey results announced yesterday by the Bazelon Center make clear that two out of three voters agree that coverage of mental illness and addiction is as im-

portant as coverage of physical illness.

It is our hope that through our appearance before you today we can convey what we believe to be very compelling reasons for your including mental illnesses and addictive disorders fully in health care reform. Later today, Mrs. Ford and I will send a letter to all Members of Congress regarding our concerns.

#### WHAT ARE THE REASONS?

Mental illnesses are a serious and pervasive problem in American society.

A recent study at the University of Michigan estimates that about three (3) out of ten (10) Americans will experience a mental disorder this year. Throughout the course of our lives, one half (1/2) of all Americans will experience at least one episode of a serious emotional problem.

Of those with the most serious and multiple problems, only one-third had received

treatment in the previous year, according to the same study.

12% of our children suffer from emotional and mental illnesses. Regrettably, here

too, only 1 out of 3 receive treatment.

Major depression accounts for more bed days-people out of work and in bedthan any disorder except for cardiovascular disease.

## MENTAL ILLNESSES ARE REAL

Research in the last decade has made it clear that some of the major mental illnesses are related to chemical and/or structural problems of the brain. They are illnesses like physical illnesses.

The majority of voters now understand this to be true, as the recent survey by

the Bazelon Center revealed.

The cost of treating mental illnesses is measurable. The cost of treating mental illnesses is 10% to 15% of our health care expenditures (estimated in 1990 to be approximately 67 billion dollars). The indirect costs to society of mental illness, in terms of lost productivity in the work place, losses due to premature death from suicide, costs in our jails and prisons, the costs for welfare and supports to our homeless are far greater than the direct costs of treatment.

# MENTAL ILLNESSES ARE AS DEFINABLE AS PHYSICAL ILLNESSES

When using well-established diagnostic criteria, mental health clinicians can agree on a diagnosis 80% of the time.

That is comparable to the reliability of diagnoses of many physical illnesses.

Mental illnesses are treatable. Some of the treatments are more effective than

treatments for some physical illnesses.

The efficacy rate for schizophrenia is 60%, for panic disorder it is 80% and for manic-depressive illness it is 80%, whereas the improvement rate for angioplasty is 41% and for atherectomy 52%.

The reality is that many treatments, based in community outpatient settings,

costing less than high-cost hospitalization, have been shown to be effective.

Treatment is cost-effective. There is increasing evidence from many of our larger corporations that a comprehensive, managed mental health benefit is effective in dealing with mental health problems and also reduces health care costs generally.

Under the Federal Employees Health Benefits Plan, patients with chronic medical

diseases who received psychotherapy for their emotional problems used 56% fewer

medical services than those who did not receive psychotherapy.

Large employers have been successful in saving money through redesign of their mental health benefit. An example is McDonnell Douglas who, in 1989, introduced a managed mental health employee assistance plan which focused on individualized patient care planning and long-term care management.

Employee absenteeism and turnover rates were reduced. During the first year, per capita costs declined by 34%. Psychiatric inpatient costs decreased 50% and chemi-

cal dependency inpatient costs dropped 29%.

Other employers, Digital, Honeywell, First National Bank of Chicago-to name a few-have also shown the cost effectiveness of a comprehensive, managed mental

health benefit.

Reviews of liberal benefit plans have shown that the mental health costs have remained between 11 and 13% for 20 years. In Canada, comprehensive mental health benefits have been about 14% of total costs. Liberal benefits have not "broken the bank.

In addition to the great financial costs to our society of individuals with mental illnesses and substance dependence, we must never lose sight of the human costs of lives unnecessarily lost, of the decreased opportunity for these individuals to par-ticipate in the major activities of daily life and the impact of these disorders on children, families, and communities. The cost of pain and suffering is incalculable.

We now have the opportunity to achieve some very significant progress in health care reform: I refer to proposals that all people will have coverage; that no one will be excluded based on a preexisting condition; that health screening will also include screening for mental health problems; and that mentally ill people will now have access to physical health care that they have not had for so many years.

Some of the current proposals continue to be problematic.

The proposal that there should be arbitrary limits imposed on either the number of visits or the amount of care is one of these. The survey I mentioned earlier makes it clear that American voters do not agree with the idea of arbitrary, discriminatory

Limiting the number of treatments arbitrarily—without regard to the individual's need, or to the severity or complexity of a problem-makes no sense. Would we think it made sense to require that someone with cancer should get no more than, say, ten radiation treatments-no matter the size, location, or growth of their tumor?

Another problem is co-payment requirements that are so high so as to exclude

people from care.

Another is to delay full coverage for mental illnesses over several years.

Individuals with mental illness have long experienced stigma and discrimination as a result of the myths and false stereotypes that have prevailed. As a result, they have been excluded from the mainstream of American life in housing, employment,

and health care. We can correct this in health care reform.

Let me end by saying that health care reform also holds great promise to do something significant about providing services for the millions of children in this country who have serious emotional problems. I would raise the possibility that, for our children, we think of making a bold, magnificent step forward to provide comprehensive services for them so that we can reduce the number of wasted lives of so many children and the painful separations of children from their families when that is not necessary and not good.

We can end the discrimination in health care. If we fail now, we won't have an-

other chance for a long time to come. Let us not fail.

Thank you.

#### PREPARED STATEMENT OF LENORE BEHAR

#### PREFACE

The Fort Bragg Child/Adolescent Mental Health Demonstration Project was undertaken by the State of North Carolina based on the principles that undergird state-of-the-art child mental health and substance abuse planning and practice. The underlying principles are:

Early detection and treatment of mental health and substance abuse problems are important to improve the likelihood of positive outcomes. Thus, it is important to improve access to services.

Each child is unique, with unique needs to be addressed by an individualized

An appropriate treatment plan results from an initial comprehensive assess-

ment and from ongoing review of treatment progress.

Services are best provided in the least restrictive setting, which for most children is in a comprehensive continuum of community services and in the context of the child's family.

The child's family is an important part of the treatment process and should

be viewed as partners by the treatment staff.

For many children, other agencies or providers are involved with the child and, therefore, cross-agency coordination must be part of the treatment process. Cost containment can be achieved through early detection and treatment of problems, through proper treatment planning, making effective use of the appropriate level of care and mix of services, and through ongoing review of treatment.

A sound and comprehensive evaluation is part of the design of this demonstration project and the full impact of the project can best be determined through this independent study. However, indications of the success of this project are found in 1) the positive feedback from families, 2) the positive feedback from mental health and substance abuse professionals who have made on-site visits, and 3) the preliminary findings of the evaluation data and the service utilization data presented in this re-

Based on their assessment of the value of this approach, the Department of the Army is issuing a request for proposals to extend the services through 1998. The state of North Carolina has used this approach in a Medicaid waiver program for

children and adolescents with mental health and substance abuse problems.

#### DESCRIPTION OF THE PROJECT

The Fort Bragg Child and Adolescent Mental Health Demonstration Project is an innovative approach for providing a comprehensive managed system of mental health and substance abuse services to approximately 46,000 (FY92) CHAMPUS-eligible children and adolescents under age 18 who reside within the Fort Bragg catchment area. The demonstration strives to better serve children and adolescents by making available and linking together a wide range of community-based mental health and substance abuse treatment services into a comprehensive continuum of care; that is, a seamless system of services. Client movement across services is planned as a part of treatment planning and accessed within the system by the program staff rather than by a referral process. This demonstration is a prime example of what experts refer to as an integrated, comprehensive, flexible services system. It is the largest child mental health and substance abuse demonstration project in the country.

The Department of the Army funded this demonstration project in 1989 through a 57-month cost-reimbursement contract with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS). DMH/DD/SAS, nationally recognized as an innovator in child and family mental health and substance abuse services, oversees the service system. Services are delivered through subcontracts with the Lee-Harnett Area MH/DD/SAS Program and the Major General James H. Rumbaugh Child and Adolescent Mental Health Clinic operated by the Cardinal Mental Health Group, Inc., a private not-for-profit corporation whose sole purpose is to provide or arrange for services under this contract. All CHAMPUS-eligible beneficiaries under age 18 who are seeking mental health or substance abuse treatment services are required to use the Rumbaugh Clinic. There are no co-payments, deductibles or charges to families for these services.

After a ten-month start-up period, the Rumbaugh Clinic began providing services on June 1, 1990. Through this project, a wide range of new community-based services were created and existing publicly and privately operated services were incorcreated and existing publicly and privately operated services were incorporated into the project through contracts. Many of the services are not traditional CHAMPUS benefits and are designed to serve both as alternatives to unnecessary hospitalization and as aftercare for necessary hospitalization. The continuum of services includes: intake-assessment services; 24-hour emergency services; 24-hour in-home crisis stabilization (family preservation); outpatient treatment; day treatment and provided the services are not read to a service of the services and provided the services are not read to a service of the services are not traditional to the services are not traditiona ment and partial hospitalization; therapeutic home, group home, larger group residential treatment; and psychiatric hospital services.

Children enter the service system through a single access point (Rumbaugh Clinic) and are provided a comprehensive assessment to identify their mental health and substance abuse needs. Through a multi-disciplinary treatment team and case management approach, the demonstration mobilizes the community's mental health and substance abuse resources and carefully coordinates each child's care to make sure he or she receives the right mix of needed services in a clinically appropriate and cost-effective manner. Services are individually planned for each child and are provided in the least restrictive setting possible. Families are encouraged to participate in the treatment planning process as well as in the client's treatment. Treatment may be provided at the Rumbaugh Clinic, in the home, at school, in therapeutic residential settings, or by contract with hospitals and private service providers in the community, as appropriate.

#### PROJECT GOALS

1. To demonstrate that, with a full continuum of care, services equal to or higher quality than what is traditionally available can be provided to more clients at lesser cost per client.

2. To demonstrate that, as an alternative to traditional

services provided through the CHAMPUS benefit, a full community-based continuum of mental health and substance abuse services for children and adolescents can be tailored to each client's needs and thus, provide a more appropriate set of treatment services with equal or better outcomes.

3. To demonstrate the effectiveness of a federal-state partnership to provide mental health and substance abuse services for military children, adolescents and their

families.

#### INDEPENDENT EVALUATION

In order to study the effectiveness of the demonstration project on a number of levels, an independent evaluation has been funded. The evaluation is being conducted by the Center for Mental Health Policy at the Institute for Public Policy Studies at Vanderbilt University through a contract from the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The National Institute of Mental Health provides a supplemental grant to Vander-bilt University. In the evaluation study, the system of services provided through the demonstration project is being compared with two comparison sites; one at Fort Campbell, Kentucky and the other at Fort Stewart, Georgia. The evaluation focus is on comparisons in the following four major areas: the outcomes of treatment; the cost of services; the quality of services; and implementation/replication issues

The quality and implementation studies were completed on September 20, 1993. The outcome and cost studies are expected to be completed by September 30, 1994.

[Additional material may be found in committee files.]

## PREPARED STATEMENT OF EDWIN C. HUSTEAD

Mr. Chairman, the Hay Group appreciates the opportunity to appear before the United States Senate Committee on Labor and Human Resources to discuss the design of the mental illness provisions of health plans of private sector employers and to compare these to the provisions of the Health Security Act as stated in Senate Bill 1779.

I am the Senior Vice President in charge of the Washington office of Hay/Huggins, the actuarial and benefits operation of the Hay Group. I lead the Hay Group's task force on healthcare reform. The Hay Group is the actuarial consultant to the Congressional Research Service (CRS).

A primary source for the analysis and information that follows is the 1993 Hay/ Huggins Benefits Report (HHBR). The HHBR, an annual report conducted for the last 25 years on the employee benefits programs of over 1,000 employers in the United States, is recognized as one of the most definitive surveys of these programs.

Benefit provisions

Employee benefits programs in the United States have traditionally limited benefits for the treatment of mental illness. Only 6 percent of the plans reported in the HHBR pay for inpatient mental illness expenses at the same level as expenses for non-mental illness. Most of the plans impose a limit on the days of treatment that will be reimbursed. The majority of the plans limit coverage to 30 days but most of the other plans cover from 45 to 120 days.

Coverage of outpatient benefits is even more severely limited. Practically all employers impose at least one limit and most use a combination. These include ceilings on the number of visits, maximum amounts paid per visit, and annual and lifetime

ceilings on the total outpatient benefit. And, many plans pay a lower portion of the bill than they do for non-mental illness. The result of these limitations is that only \$1,000 to \$2,000 of an episode of treatment is reimbursed by the health plan per

A feature that results in very disparate treatment of mental and non-mental illness is the application of the maximum out-of-pocket limits in the reimbursement of expenses. These pay for the full cost of non-mental illness after a specified amount is paid out-of-pocket—usually \$500 to \$2,000 a year. Mental illness benefits are not considered in this out-of-pocket limit. As a result, the mental illness patient must bear the full cost after the maximum days and visits are reached.

For example, a 45 day stay in a psychiatric hospital could cost about \$35,000 with outpatient expenses of \$10,000. Most plans would pay about half of the hospital bill and only \$1,500 of the outpatient expenses. The patient would have to pay around \$24,000 for this treatment. Of course, many patients could not afford these limits

and would have to forgo necessary treatment

By contrast, the typical plan would pay all but \$1,000 of the bill for non-mental illness expenses. This is not a trivial out-of-pocket payment but it is affordable to most employees and would seldom result in the patient forgoing necessary treat-

The initial benefits in S. 1779 do limit the reimbursement of mental illness benefits. However, even the initial benefits are much more liberal than those found in

most employer health plans.

S. 1779 starts with the typical limit of 30 days per episode for inpatient treatment. However, the provisions then move to a much more flexible treatment of both inpatient and alternative cue. The plan will cover: additional 30 days a year if treatment in a hospital is medically necessary and the best alternative. Further, up to 120 days of intensive non-residential treatment can be substituted for inpatient care. The substitution is reinforced by a provision that use of two days of non-resi-

dential treatment will reduce the inpatient treatment limit by one day.

Outpatient psychotherapy is limited to 30 visits per year. However, exceptions are made for monitoring and managing care and additional outpatient visits can be sub-

stituted for inpatient treatment at a rate of four visits for one inpatient day.

The initial higher cost-sharing plan would pay \$38,500 of the \$45,000 of expenses in the above example. The \$6,500 out-of-pocket may still be a barrier to appropriate treatment but it is much less burdensome than the current situation that requires half of the expenses to be paid by the employee. The phased-in benefits of S. 1779 would remove the mental illness benefit limits reducing the out-of-pocket expenses in the example to \$1,500.

Cost of mental illness benefits

A welcome outcome of the debate on national health care proposals has been that actuaries have compared their analytic models and assumptions. In that process we have found broad areas of agreement on the cost of mental illness benefits in the United States. If actuaries can agree on the cost of S. 1779 and other proposals, you will be able to focus on the trade-off of provisions of equal value without having to endure a long debate on what that equal value is.

The Health Care Financing Administration (HCFA) developed the cost of the Health Security Act of mental illness benefits by building on the estimated cost of health benefits provided through existing private and public sector plans. HCFA started with a private sector cost of \$141 per person per year in 1994. Milliman and Robertson, in their report on Managed Behavioral Healthcare Costs, estimated a cost of \$139 per person per year for a typical managed indemnity plan. Another large actuarial firm, Hewitt Associates, estimated a cost of \$143 for that plan in their testimony before the House Committee on Energy and Commerce last December. Our data also show a cost of around \$140 per person per year.

There has been a tendency in past debates on mental illness cost to take numbers out of context. Many have used these out-of-context numbers to argue that mental illness benefits are "too expensive". In fact, the cost of mental illness benefits has been well known and changes in that cost have been very similar to changes in the cost of the total health package. In studies over the last two decades, I have found that the cost of the mental illness package for a typical plan has consistently been about 8 percent of the cost of the total package.

about 8 percent of the cost of the total package.

Critics of mental health coverage have also pointed out that most of the mental illness dollars are spent for a small number of beneficiaries. I am puzzled by this argument as a reason to limit mental illness benefits. The very essence of insurance is to protect the individual against the high cost of major health problems. The very small number of people using the most expensive treatments is a feature of most benefits in the health package.

Employer and insurer concern about the concentration of expensive treatment are reflected very differently in the mental and non-mental parts of the typical health plan. The maximum out-of-pocket limits were added to policies to insulate the employee against high expenses of major non-mental illnesses. Mental illness benefits stop entirely when days and visits exceed specified limits. The employees pay nothing for continuing treatment for expensive non-mental illness and, if they can afford

it, all of the cost of continuing treatment for expensive mental illness.

The American Academy of Actuaries, in recognition of the need for clear and com-The American Academy of Actuaries, in recognition of the need for clear and comprehensive analysis of health care proposals, has established fifteen work groups to provide the Congress with detailed information on the cost and design of all aspects of proposals for national health care reform. The Academy's Mental Health Benefits Work Group, which has members with wide and diverse experience in the design and pricing of mental illness coverage, is completing its report on the cost and design of mental illness benefits. That report should be available in a few weeks and will both critique the validity of the HCFA estimates and provide a basis for accurate and consistent estimation of the cost of proposals for mental illness benefit coverage. erage.

#### PREPARED STATEMENT OF BETTY FORD

MR. CHAIRMAN - MEMBERS OF THE COMMITTEE --I DEEPLY APPRECIATE THE OPPORTUNITY AND THE HONOR OF APPEARING BEFORE YOU WITH MRS. CARTER. ROSALYNN AND I REPRESENT TWO PARTS OF AN ISSUE WE BELIEVE MAY BE SHUNTED ASIDE IN THE MOVE TO REFORM OUR HEALTH CARE SYSTEM. SUCH AN OMISSION PRESENTS A GREAT DANGER FOR THE FUTURE SUCCESS OF THIS REFORM.

SUBSTANCE ABUSE IS EMPHATICALLY NOT AN EXPENSIVE ADD-ON TO AN ALREADY STRAINED SYSTEM. RECENT STUDIES OF OVERALL HEALTH CARE SPENDING INDICATE THAT SUBSTANCE ABUSE TREATMENT COMPRISES ONLY 1-3 % OF MEDICAL COSTS. THE REAL COST TO OUR SOCIETY WILL BE IN IGNORING ALCOHOL AND DRUG DEPENDENCE TREATMENT. SUCH TREATMENT IS AN IMPORTANT COST SAVING COMPONENT OF HEALTH CARE REFORM. SOCIETY WILL REAP LARGE BENEFITS IMMEDIATELY AND RECURRENTLY FROM SUCH COVERAGE. AS I CONTINUE MY TESTIMONY I WILL REFER TO ALCOHOL AND DRUG DEPENDENCE - A MORE ACCURATE TERM FOR SUBSTANCE ABUSE.

WHEN AN EMPLOYEE RETURNS TO WORK AT FULL CAPACITY, A FATHER RETURNS TO GIVE FULL GUIDANCE AND CARE TO HIS CHILDREN, A COMMUNITY LEADER RETURNS TO HIS COMMUNITY BETTER ABLE TO WORK TO SOLVE THE FROBLEMS FACING OTHERS BECAUSE HE HAS DEALT SUCCESSFULLY WITH ONE OF HIS OWN - WE ALL BENEFIT.

ALCOHOL AND DRUG DEPENDENCE IS A MAJOR UNDERLYING ELEMENT THROUGHOUT OUR HEALTH CARE SYSTEM AND THROUGHOUT EVERY OTHER ASPECT OF OUR SOCIETY -- BUSINESS AND INDUSTRY, THE CRIMINAL JUSTICE SYSTEM, SOCIAL SERVICES AND EDUCATION.

I KNOW THAT TREATMENT FOR ALCOHOL AND DRUG DEPENDENCE WORKS. THERE ARE NO GUARANTEES FOR SUCCESS FOR EVERY PERSON WHO UNDERGOES TREATMENT. BUT THE STANDARD OF SUCCESSFUL TREATMENT PROGRAMS STANDS AT ABOUT 65-70%. THIS EXCEEDS THE RECOVERY RATES FOR MOST OTHER CHRONIC DISEASES.

I KNOW FROM MY PERSONAL AND PROFESSIONAL EXPERIENCE THAT SUBSTANCE ABUSE IS A CHRONIC DISEASE... ONE THAT CAN BE DIAGNOSED AND SUCCESSFULLY TREATED. THE AMERICAN MEDICAL ASSOCIATION AND THE WORLD HEALTH ORGANIZATION DESIGNATED IT A DISEASE AS EARLY AS 1956.

I CAME HERE TODAY BECAUSE I AM FIRMLY CONVINCED THAT
UNLESS TREATMENT FOR ALCOHOL AND DRUG DEPENDENCE IS
INCLUDED IN REWORKING OUR HEALTH CARE SYSTEM WE WILL NEVER
ACHIEVE COMPLETE AND SUCCESSFUL REFORM.

TODAY, THE COST ASSOCIATED FOR INDIVIDUALS WITH ALCOHOL AND DRUG DEPENDENCE UNDERMINES THE CHANCE OF REFORM AS SURELY AS THE DISEASE DESTROYS THOUSANDS AND THOUSANDS OF AMERICAN LIVES EACH YEAR. SEVERAL RECENT HEALTH ECONOMIC STUDIES INDICATE THAT BY ASSURING THE AVAILABILITY OF ALCOHOL AND DRUG TREATMENT SERVICES UNDER HEALTH CARE REFORM, WE CAN SAVE ENORMOUS SUMS IN THE LONG RUN. THE PRESIDENT'S COMMISSION ON MODEL STATE DRUG LAWS STATES

THAT FOR EVERY DOLLAR SPENT FOR TREATMENT, TEN DOLLARS ARE RETURNED TO THE ECONOMY.

ALCOHOL AND DRUG DEPENDENCE RESULTS IN EXCESSIVE MEDICAL AND SOCIAL COSTS WHICH INFLATE THE COST OF HEALTH CARE IN THIS COUNTRY. STUDIES, INCLUDING ONE DONE BY THE ROBERT WOOD JOHNSON FOUNDATION, PLACE THE CURRENT COST ESTIMATE AT \$240 BILLION DOLLARS ANNUALLY. THAT IS ROUGHLY \$1000 FOR EVERY MAN, WOMAN AND CHILD IN AMERICA. THE AMERICAN MEDICAL ASSOCIATION ESTIMATES THAT ALCOHOL AND DRUG DEPENDENCE IS RESPONSIBLE FOR AT LEAST 40% OF ALL HOSPITALIZATIONS. ALSO INCLUDED ARE THE COST OF AUTO ACCIDENTS, INCREASED CRIME AND THE SUBSEQUENT DEMAND FOR INCREASES IN LAW ENFORCEMENT -- AND THE LOST PRODUCTIVITY FOUND IN BUSINESS AND INDUSTRY DUE TO ABSENTEEISM AND ACCIDENTS.

ALCOHOL AND DRUG DEPENDENCE DEVASTATES FAMILIES BOTH
EMOTIONALLY AND FINANCIALLY. ONE OUT OF 4 AMERICANS
EXPERIENCE FAMILY PROBLEMS DIRECTLY LINKED TO ALCOHOL AND
DRUG DEPENDENCE. IT PLAYS A PART IN ONE-THIRD OF ALL
FAILED MARRIAGES. IT IS SUSPECTED THAT MORE THAN 50% OF
THE DOMESTIC VIOLENCE AGAINST WOMEN OCCURS UNDER THE
INFLUENCE OF DRUGS AND ALCOHOL. THE CORRESPONDING TOLL ON
THE CHILDREN INVOLVED IS IMPOSSIBLE TO CALCULATE.

A RECENT GALLUP POLL INDICATED THAT OVER 70% OF AMERICANS
BELIEVE THAT ALCOHOL AND DRUG DEPENDENCE IS A DISEASE THAT
SHOULD BE TREATED IN A HOSPITAL OR HEALTH CARE
INSTITUTION. YET, AS I MENTIONED PREVIOUSLY ONLY ABOUT
ONE-TENTH OF THOSE NEEDING TREATMENT ACTUALLY RECEIVE IT.

THOSE FORTUNATE ENOUGH TO RECEIVE HELP REPRESENT A SIZABLE

NET BENEFIT FOR HEALTH CARE. HOSPITALIZATION RATES ARE

CUT IN HALF AFTER TREATMENT. EMERGENCY ROOM USE, MEDICAL

AND PSYCHIATRIC ADMISSIONS ALL ARE SIGNIFICANTLY REDUCED AFTER TREATMENT.

THESE SAVINGS CAN BE EXTENDED TO FAMILY MEMBERS AS WELL.

THE RECENTLY RELEASED EVALUATION FOR THE PRESIDENT'S

COMMISSION INDICATES: "HEALTH CARE CLAIMS OF FAMILY

MEMBERS WHEN THEIR ALCOHOLIC RELATIVE RECEIVED APPROPRIATE

TREATMENT FELL OFF BY 50%."

SUCCESSFUL, QUALITY TREATMENT CAN YIELD OTHER EXCELLENT RETURNS. ABSENTEEISM AND JOB RELATED PROBLEMS SHOW MARKED REDUCTIONS AFTER TREATMENT. THIS YIELDS SIGNIFICANT SAVINGS TO INDUSTRY. AUTO ACCIDENTS AND ARRESTS DECREASE FOURFOLD AFTER TREATMENT. THIS REDUCTION PROVIDES REAL SAVINGS IN INSURANCE AND PUBLIC SAFETY COSTS. TREATMENT FOR ADDICTION IS ONE OF THE FEW AREAS OF HEALTH CARE WHERE THE TREATMENT RECEIVED WILL MAKE A LONG-TERM CONTRIBUTION TO THE REDUCTION OF HEALTH CARE COSTS.

REFORM IS TAKING PLACE NOW. FOR THAT REFORM TO BE

EFFECTIVE I AM CONVINCED A COMPREHENSIVE BENEFIT COVERING

QUALITY TREATMENT OF ALCOHOL AND DRUG DEPENDENCE AND

MENTAL ILLNESS MUST BE A SIGNIFICANT PART OF ANY

LEGISLATIVE PACKAGE. THERE IS INDEED A COST INVOLVED AT

THE TIME OF TREATMENT, BUT THE REWARDS AND THE COST

SAVINGS FOR THE FUTURE WILL BE MULTIPLIED MANY TIMES OVER.

SECRETARY JOE CALIFANO, NOW CHAIRMAN OF THE CENTER ON ADDICTION AND SUBSTANCE ABUSE, MAY HAVE PUT THE ISSUE MOST SUCCINCTLY: "WITHOUT AN ALL-OUT ATTACK ON THE NATION'S NUMBER ONE HEALTH PROBLEM - SUBSTANCE ABUSE AND ADDICTION - REFORMS DESIGNED TO PROVIDE HEALTH CARE FOR ALL AMERICANS AT A REASONABLE COST ARE DOOMED TO FAIL." I AGREE WHOLEHEARTEDLY WITH THIS EVALUATION.

MR. CALIFANO IS NOW AT THE FOREFRONT OF TELLING US THAT WITHOUT ADDRESSING ALCOHOL AND DRUG DEPENDENCE WE CAN'T ACHIEVE REFORM. AND WE NEED TO ACHIEVE THAT REFORM. WE CAN NOT AFFORD THE LIVES OR THE DOLLARS AT RISK IF WE WAIT FOR MR. CALIFANO TO BE PROVED RIGHT.

I APPLAUD THE MEMBERS OF THE COMMITTEE WHO WERE PART OF THE GROUP WHO SENT A LETTER TO IRA MAGAZINER THIS PAST NOVEMBER. I WAS VERY PLEASED THAT IN THAT LETTER, YOU OPPOSED SETTING ARBITRARY, PRE-DETERMINED LIMITS ON TREATMENT FOR MENTAL HEALTH AND SUBSTANCE ABUSE.

I SINCERELY ASK YOU - ALL THE MEMBERS OF THE SENATE LABOR AND HUMAN RELATIONS COMMITTEE - TO GIVE CAREFUL CONSIDERATION TO THIS ISSUE IN ALL ITS ENORMITY. THIS IS A PLEA MRS. CARTER AND I ARE MAKING TO ALL THE MEMBERS OF CONGRESS IN A LETTER BEING SENT OUT TODAY.

THANK YOU FOR THE KINDNESS AND CONSIDERATION YOU HAVE SHOWN IN ALLOWING ME TO TESTIFY. HAVING HAD THE PRIVILEGE OF SERVING THIS NATION AS FIRST LADY, I REALIZE THE RESPONSIBILITY OF SPEAKING OUT ON ISSUES THAT CONCERN OUR COUNTRY. I APPRECIATE THE UNIQUE OPPORTUNITY YOU HAVE GIVEN ROSALYNN AND ME IN APPEARING TOGETHER TODAY.

# United States Senate

November 17, 1993

Ira Magaziner Senior Adviser for Policy Development The White House Washington, D.C. 20500

Dear Ira,

We have reviewed the 11/14/93 release of changes in the Mental Illness and Substance Abuse Provisions in the Health Security Act. As you are aware, the Senate Working Group on Mental Health believes that comprehensive and flexible benefits provided under a well-managed system are very achievable, and would be more effective and more cost efficient than the plan presented in the Health Security Act. The enclosed testimony and summary of the November 8 hearing before the Senate Committee on Labor and Human Resources highlight our case for such benefits.

In addition, we are concerned that there are a number of problems with the Health Security Act that must be addressed, even in the context of a traditional benefits plan that relies on day limits, heavy deductibles and co-payments to restrict utilization. While we recognize your serious attempt to deal with difficult issues in the 11/14 document, we still have concerns with the revised model. Several significant aspects of the plan should be changed in order to meet the Administration's own goals of security and simplicity.

We would appreciate your consideration of the following issues and questions:

#### INPATIENT SERVICES

1. Meeting the criteria for additional days: The revised benefits provide 30 days of inpatient treatment. An additional 30 days may be approved if a health professional determines that the patient either poses a threat to his or her own life or that of another, or requires hospitalization to initiate, alter or adjust pharmacological or somatic therapy.

Many situations exist where patients may be seriously disturbed with a medical or psychological necessity for inpatient care but would be unable to meet the stated definition and access the additional 30 days.

2.  $\underline{\text{D}} \text{educt} \underline{\text{tible}} \colon$  The revised plan continues to require a one-day deductible for inpatient care.

As Hewitt Associates strongly stated at the November 8 hearing, they know of no plan that now uses the one-day deductible as a way to keep costs down. The one-day deductible is likely to save 55 per covered life, yet would put an unconscionable burden on those who can least afford it -- emotionally or financially.

#### INTENSIVE NON-RESIDENTIAL SERVICES

- 1. Differential treatment costs: The types of treatment listed are not actuarially equivalent yet are made so by the 2 for 1 substitution. The listed treatments vary greatly in actual cost. For example, partial hospitalization, day treatment, and psychiatric rehabilitation services are likely to be more expensive than a second group of non-residential services, namely the home-based, ambulatory detoxification and behavioral aide services. If the equivalent cost of services is the basis for this trade-off, we would suggest that for this second group, I inpatient day should be equal to 4 days of alternative care.
- 2. <u>Deductible and co-insurance</u>: The 1-day deductible and the 50% co-payment for the second 60 days continue the assumption that the plan must hit people hard at the beginning of treatment and at points during treatment in older to keep costs down. This model perpetuates the concept that people are frivolous in seeking help through these therapies. It also negates the entire concept of good, high quality managed care that provides the best treatment for the patient at that time in the patient's life.

Patients will be financially forced into choosing a type of treatment because of its co-payment or out-of-pocket cap rather than basing such serious decisions on what will help them get well.

#### OUTPATIENT SERVICES

- 1. Reduced number of visits: We are seriously concerned that the number of visits for outpatient psychotherapy and collateral services has been cut in half. The original plan allowed for 30 visits for each treatment modality. This reduction is a serious stack on a low-cost and yot highly effective plan benefit. Given the actuarial data concerning outpatient psychotherapy, moving to an increased benefit would make more fiscal and preventive sense than this reduction to a total of 30 visits.
- 2. <u>Limits and co-insurance</u>: We are dismayed by the Administration's apparent unwillingness to recognize the wealth of data that show the financial advantages of an open outpatient benefit and the unreasonableness of a limited 30-visit outpatient benefit <u>end</u> a 50% co-insurance. The data speak both to the very low cost of removing the day limit and to the administrative nightmare that these limits and the collection of co-payments would create in exchange for little or no cost savings.
- 3. Out-of-pocket cap: For both the outpatient benefits and the intensive non-residential benefits, we feel strongly that not counting these expenses toward the out-of-pocket cap works adversely on those who need these benefits to improve their lives, perhaps, even to save their lives.

We do have several specific questions raised by the 11/14/93 memo we hope you will answer for us.

#### QUESTIONS/CLARIFICATIONS

- 1. <u>In-patient deductible</u>: What would be the deductible for the low cost-sharing option? Would it apply to each admission?
- 2. <u>Means-testing for benefits</u>: Is there any plan to means-test any of the mental health and substance abuse benefits?
- 3. <u>Intensive non-residential co-payment</u>: Do the deductible and co-payment paid by the patient during the first 60 days count toward their out-of-pocket cap? Is there a difference between the high and low cost-sharing plans in terms of the one-day deductible and/or co-payment during the first 60 days?
- 4. How does the plan define "somatic illnesses" and "somatic treatments"? These are central to both the inpatient extension of days and to outpatient psychotherapy.

#### SUMMARY

We are very concerned that the mental health and substance abuse benefits as now presented will not gain the support of the American people for two primary reasons:

(a) It would be less than many people now have; and, (b) it would create such additional bureaucracy that cost savings in the first three years would be difficult to achieve. That would endanger the phase in of additional benefits in 2001.

We ask that the health plan reflect the large research base that shows the importance of using psychological criteria as well as medical criteria for establishing treatment necessity.

We urge you to re-examine this subject with an openness to new, more recent data, and with a willingness to take issue with those who encourage more administrative restrictions that add to the costs when the goal is to save money. We know that the idea behind the inclusion of mental health and substance abuse benefits is a good one. We fear, however, that the amended plan encourages treatment that may not be in the best interest of the patient and does it by artificially manipulating the patient's cost of obtaining care.

Thank you for your consideration of these important issues. We look forward to hearing from you.

Sincerely,

Paul D. Wellstone

Daniel, K./ Inouye

Paul Simon

Illato

Edward K. Kennedy

Pete V. Domenici

Alan K. Simpson

# PREPARED STATEMENT OF HAROLD E. HUGHES

Mr. Chairman and members of the Committee: Thank you for giving me this opportunity to testify today.

As some of the members of this committee know, as a member of the U.S. Senate in January 1969 I was assigned to the Labor, Health, Education, and Welfare Committee, as it was called then.

During that time, I asked Chairman Yarbrough of Texas to establish a new subcommittee on alcoholism and other drug dependency. He said Senator Kennedy, who chaired the Health Subcommittee, would have to be willing to relinquish jurisdiction over the subject matter, or it could not be done. As the Chairman knows, he gave the jurisdiction and asked to serve on the new Subcommittee as well.

The first committee hearings were held in July 1969 and heard Bill Wilson, who 34 years earlier was one of the founders of Alcoholics Anonymous. We also heard Marty Mann, considered the "first lady" of the alcoholism movement, who 25 years earlier founded the National Council on Alcoholism. Their testimon; helped craft our legislation, from which grew the landmark efforts of our government to confront addiction disease for the first time in our history and as a matter of fact in the history of the world.

Mr. Chairman, I return today to call for a similar landmark event in the history of addiction disease.

I am a classic victim and survivor of addiction disease. I was the son of an alcoholic father, extremely capable and striving for perfection as a youngster. I excelled at almost everything I did — as an athlete, a musician, a student, and, yes, as a soldier who fought in three campaigns as a rifleman.

After surviving three campaigns of combat, I was returned to the United States and reassigned to stateside duty. My disease of alcoholism was progressing and resulted in my being jailed numerous times for public drunkenness. I was eventually placed in a psychiatric unit — which was of no help because they knew nothing of addiction disease. I finally was

discharged with an active disease of alcoholism, which no one could diagnose in those days.

In 1948, legal information was filed with the county court to have me committed to an insane asylum. I legally evaded these charges. In 1950, I attempted suicide. In 1954, I walked away from being jailed for DWI. I have now been abstinent for 40 years.

For centuries, there was no treatment, no help, nowhere to go for people like me. Tens of thousands of Harold Hugheses have rotted in fails, prisons, insane asylums, and in the

streets. It still happens. But not because we don't know any better.

We can document more than ten million Americans like myself who have suffered from addiction disease but today lead happy, productive lives in recovery. And I know that figure is

More important to the work of health care reform this committee has been called upon to enact is the fact that when people get treatment, total health care costs go down.

Since our work 25 years ago, ample evidence has been produced to prove my point. With my testimony today I am presenting to this committee some of this highly qualified, well-documented research.

Mr. Chairman, we have been at some pains in recent years to demonstrate that treatment for addiction disease works. The pain comes not from our careful review of the facts, but from a national attitude and mindset that denies the impact of addiction and is ignorant of the results of treatment.

This stigma, and the resulting lack of knowledge, is tragic, wrong, and expensive. But as long as that stigma exists, it will be difficult for the evidence of success to be fully appreciated

by American taxpayers and policy makers like yourselves.

I am here today as founder and chairman of the Society of Americans for Recovery, this nation's only citizen-based, grass-roots organization of people in recovery from alcoholism and drug addiction. We speak for more than ten million Americans who no longer drive our health care costs through the roof.

We are not here because we need treatment. We are living productive, tax-paying lives

with lower average health care costs than other Americans.

We are not here to protest the discrimination that daily afflicts our lives — even though that is an important issue for our organization and must be faced by Americans sooner or later.

We are here as evidence that addiction disease treatment not only works — it pays.

We are frustrated and angry that the current health care debate frames adequate care for

addiction disease as a luxury add-on, or a do-gooder social benefit.

The fact is, untreated addiction is at the root of America's runaway health care costs — as well as many other economic and social ills. In the workplace alone the economic costs of drug and alcohol use exceed \$150 billion a year. Every year, every American pays more than \$1,000 in taxes, health care costs, crime, and losses in the workplace due to untreated addiction.<sup>2</sup> Yet we allow these same Americans to believe that addiction is not their concern or problem.

On behalf of the millions of Americans who have successfully moved beyond their addiction histories (and though we are quiet and mostly anonymous, Senators, let me assure you that we vote), I want to inject into this debate on health care reform important data to prove that treatment without limits for addiction disease is the best bargain Americans have

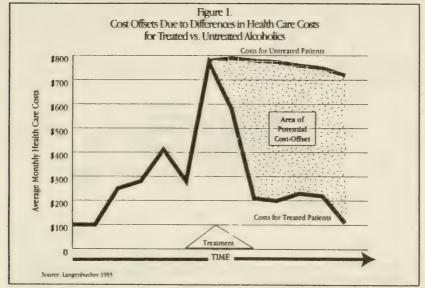
Since we passed the Hughes Act in 1970, a generation of highly qualified economic research has documented the enormous cost-cutting results of treatment. Even without the advances that have been brought to the field in recent years, studies have demonstrated that addictions treatment significantly reduces overall health care utilization by alcoholics, drug addicts,4 and even their family members.5

We have long documented the cost of untreated addiction. In health care alone, alcohol and drug abusers and addicts consume a disproportionate share of the nation's health care budget. Let me trace for you the findings of a significant study of the cost progression.

In a study of Aetna health insurance claims for nearly two thousand individuals, 6 the health costs of alcoholic patients rose gradually from about \$130 a month to \$179 for several years prior to referral for addictions treatment. About six months prior, demand for care rose to \$452 per month, and then to \$1,370 in the month before referral.

This "peaking" prior to adequate diagnosis and referral is shown in several different studies conducted on different populations, and it is common to all chronic diseases [see Figure 1]. It reaches catastrophic proportions for this particular chronic disease because society and health care providers too often turn away from the evidence.

Continuing our review of the hard evidence, however, let's find out what happens after



treatment. And remember these are gross studies of a database — not individual results. We are including people with varied treatment outcomes — not all successful by everyone's frame of reference.

Costs drop from that high of \$1,370 per month to \$294 per month in six months following treatment, then down to \$190 per month by the third post-treatment year.

These diminishing costs continue for many years, are equally marked in males and females, and are most marked in the health care histories of the youngest patients with predominate patterns of mixed substance intakes.

All expenditures for treatment are returned in lower health care costs for the individual and the family within three years. Within five years, gross health care costs for the entire family unit fall below the national average — and stay that way [see Figure 2].

Additional studies, which I reference, document thoroughly the sound economic

reasons why health care reform must respect these findings

Mr. Chairman, as you know, the cultural and social costs of addiction have long been ignored. Our society was formed to reverse that ignorance. But today, I ask only that the financial costs not be ignored

We, the victims and survivors of addiction disease, do not ask you for any more than any other American. Nor do we seek to take money or attention away from any victims of other

diseases needing medical attention.

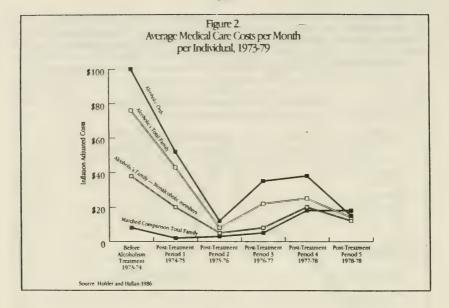
We simply ask that you treat us like all other Americans. And in doing so, you will not only help people you know in your own lives who need this help, but you will be helping all Americans to enjoy a health care system that is affordable, and an America much freer of accidents, crime, homelessness, and deteriorating family and community life

We ask not only for the millions of Americans who will need treatment in this and future

generations, but for the viability of health care for all Americans.

Universal access to a uniform package of addiction disease benefits, equal to those provided for any other chronic, progressive disease, is not only excellent public health policy, it is our only hope for a health care system that works for all Americans.

Thank you.



### **ENDNOTES**

- "Business Continues to Pay a Major Price for Substance Abuse in the Workplace," Drug Abuse News, November 1993.
- 2. Based on total annual expenses of approximately \$300 billion annually, as cited in Langenbucher et al. and confirmed in private conversation with Harwood.
- Holder, H.D. "Alcoholism Treatment and Potential Health Care Cost Savings." Medical Care, 25(1987):52-71. Cited in Langenbucher et al. 1994.
- Yu, J., P-J. Chen, E.J. Harshman, and E.G. McCarthy. "An Analysis of Substance Abuse Patterns, Medical Expenses and Effectiveness of Treatment in the Workplace." Employee Benefits Journal, September 1991:26-30. Cited in Langenbucher et al. 1994.
- Holder, Harold D., Ph.D., and Jerome B. Hallan, Dr.P.H. "Impact of Alcoholism Treatment on Total Health Care Costs: A Six-Year Study." Advances in Alcohol and Substance Abuse, 6(1986); and Spear, S.F., and M. Mason. "Impact of Chemical Dependency on Family Health Status." International Journal of the Addictions, 26(1991):179-87; Both cited in Langenbucher et al., 1994. Woodside, M., K. Coughey, and R. Cohen. "Medical Costs of Children of Alcoholics: Pay Now or Pay later." Journal of Substance Abuse, 5(1993):281-87; cited in Langenbucher 1994.
- Holder, H.D., and J.O. Blose. "Alcoholism Treatment and Total Health Care Utilization and Costs." *Journal of the American Medical Association*, 256(1986):1456-60.
- 7. Holder and Hallan, 1986.

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Langenbucher, James W., Ph.D., Barbara S. McCrady, Ph.D., John Brick, Ph.D., and Richard Esterly, M.H.S. Socioeconomic Evaluations of Addictions Treatment. Prepared by request of the President's Commission on Model State Drug Laws. New Brunswick, NJ: Center of Alcohol Studies, Rutgers University, 1994.

> For further information, call Johnny W. Allem or Martha E. Rothenberg 202-347-4257 or 1-800-838-SOAR

Huch Hughes (hursen od) such



Johnny W Allem President

March 21, 1994

Senator Edward M. Kennedy SR-315 Russell Senate Office Building Washington, DC 20510-2101

RE: <u>Labor and Human Resources Committee — Hearing of March 8, 1994:</u> <u>Supplemental Comments for the Record</u>

#### Dear Senator Kennedy:

I would like to thank you, both personally and on behalf of SOAR and the millions of Americans in recovery from addiction, for the opportunity to testify before the committee on Tuesday, March 8. I am writing today to add to the record vital information on the cost benefits and offsets of addiction treatment, and to address some of the questions raised by the committee.

The false myth persists that treatment for alcohol and drug addiction is a costly add-on — an unaffordable luxury in an already burdened health care system. Nothing could be further from the truth.

Comprehensive, flexible, universal treatment benefits for alcohol and drug addiction promise to be the best bargain the American taxpayer has ever seen. In fact, genuine health care reform — and genuine economic and social healing — will be doomed without it.

The results of nearly two generations of research on the socioeconomic effects of addiction consistently and irrefutably support this statement. Much of that literature has conveniently been evaluated and presented in a study to be published as Volume 6 of the Report of the President's Commission on Model State Drug Laws, a bipartisan group assembled at the direction of President Bush and continuing its work under the Clinton Administration. A copy of that report is attached.

The American people currently pay nearly \$300 billion a year for the consequences of <u>untreated</u> addiction. Confining my remarks to the health care problem alone, the promise of comprehensive treatment can be summarized in three main points:

- Untreated drug and alcohol addicts use up to 4 times the level of health care services as do non-addicts. These services go to treat everything <u>but</u> their primary disease: secondary effects like trauma, liver and pancreas damage, heart disease, hypertension, etc. What's more, the level of services provided "ramps up" sharply each time the addict approaches a crisis with his/her primary disease.
- Once the addict receives treatment, his/her health care costs drop to the normal range very quickly. Treatment pays for itself in savings on health care alone within 3 years.
- 3. Most remarkable is that these observations apply equally to the addict's entire family. The families of untreated addicts also have inordinately high health care costs (possibly due to the indirect effects of the stress of living with an active addict, as well as the direct effects of such things as physical abuse). Those health care costs also return to the normal range within the 3-year timespan mentioned above.

These observations are not "flukes": they are based on many different studies of literally millions of subjects in various economic and health care situations. They are consistent, reliable, and replicable. More important, they hold true in the aggregate, regardless of whether any single individual addict achieves long-term recovery.

Several questions arise repeatedly in the ongoing discussions of health care.

# If a comprehensive addiction benefit is offered, won't the demand outstrip the system's ability to provide care?

Sadly, this so-called "woodwork effect," in which millions of previously invisible addicts swarm to take advantage of a new opportunity for treatment, is just not realistic. The historical record shows that less than 1 percent of all drug and alcohol addicts with treatment coverage have ever actually claimed the benefits to which they were entitled.

# Shouldn't benefits be linked to the individual's success in staying clean and sober?

As the studies cited above demonstrate, the success of any individual addict to obtain long-term recovery is irrelevant in the larger economic picture; treatment still pays off.

That these questions have been raised at all demonstrates the ignorance and stigma with which the diseases of addiction are still viewed. No other disease raises such alarms. No one suggests that access to heart surgery be restricted because "everyone will want it." No one — not even the insurance companies — suggests that the person who has had six bypass operations and continues to smoke, drink, and eat red meat every day should be denied the seventh operation. This focus on the individual ignores the larger picture: treatment works.

# If treatment for addiction is so cost effective, why don't private insurance carriers routinely include a benefit?

Private insurance carriers achieve short-term savings through the use of managed care gatekeepers, who routinely deny access to appropriate treatment or place arbitrary caps on the extent of treatment. Because the average length of time an individual is covered under any one policy is 18 months to 2 years, insurance companies can ignore long-term savings. And, of course, individuals with "pre-existing conditions" are excluded from most policies.

Recovery rates of patients receiving appropriate, good quality treatment are about 65 percent. (This is a respectable rate of recovery for treatment of any disease, but will probably improve as more resources are devoted to addictions research.) I emphasize that this is the result not of "expensive" treatment, but of appropriate

treatment. Proper matching of patient condition to course of treatment is vital to the success of treatment. This is why the "gatekeepers" (those who will decide what treatment will be allowed) must be fully qualified specifically in assessing addiction disease. Our greatest concern about the combined mental health/addiction benefit is that the majority of mental health practitioners are not qualified to diagnose or treat addiction. Likewise, the majority of utilization reviewers have little or no training in addiction disease. Proper training of gatekeepers is a crucial element of an addiction benefit that works.

In summary, a comprehensive and flexible addictions benefit, managed by gatekeepers who are properly trained in assessment and who match treatment service to patient need, is essential to genuine and lasting reforms and savings in health care.

Sincerely,

Senator Harold E. Hughes (Ret.)

Founder and CEO Society of Americans for Recovery

# PREPARED STATEMENT OF RONALD GERATY

Mr. Chairman, Members of the Committee, thank you for conducting this hearing and for highlighting the need for treatment of those patients who suffer from psychiatric and chemical dependency illnesses. My name is Ronald Geraty. I am a child and adolescent psychiatrist and am currently Executive Vice President of the largest managed behavioral healthcare corporation in the U.S. In that capacity, I have spent the last several years planning efficient behavioral treatment programs for insurance companies, HMOs, PPOs, employers and unions.

It is from that perspective, that I have arrived at the conclusions that:

- Treatment of mental illness and chemical dependency has been demonstrated to be clinically effective and cost-effective and is a necessary component of any comprehensive healthcare benefit package;
- The goals of improved access, demonstrated quality and cost-effectiveness have been illustrated only in a managed care environment; and,

3) Equivalent benefits for behavioral health are affordable NOW.

Dramatic new evidence, just released last month, demonstrates that psychiatric and chemical dependency treatment is affordable in both the employed and Medicaid populations. These studies are important because they cover large populations AND especially because these are not analyses, projections or actuarial studies: these studies report ACTUAL EXPERIENCE.

Each of these studies was conducted in a managed behavioral care environment and demonstrates:

Greater Access,

Lower Cost, and

**Demonstrated Quality.** 

The American Managed Behavioral Healthcare Association (AMBHA) is an organization formed by 15 of the largest and most experienced managed behavioral care companies in the U.S. AMBHA commissioned Milliman and Robertson, one of the country's leading actuarial consulting firms, to study the cost of providing treatment with the benefits as proposed in the Health Security Act (HSA). With those benefits, in an employed population covering 35 million lives, the actual cost of providing the treatment was \$139 per person per year in a managed indemnity plan (equivalent to the high option benefit in the HSA plan), \$75 in a point-of-service plan (equivalent to the blended option in the HSA plan), and \$42 per person per year in an HMO (equivalent to the low option in the HSA). These results contrast sharply with earlier estimates from HCFA and other analyses.

Of course, the AMBHA study was conducted on an employed population. But again last month, Brandeis University released a study it had conducted on the

Massachusetts Medicaid program where a managed behavioral care company managed the care of all Medicaid recipients in the first statewide managed mental health program in the country. Brandeis reported that an annual trend of cost increases was dramatically reversed and at the same time access was improved and quality demonstrated. In the Brandeis study covering 1993, costs were decreased by 22%, saving the Medicaid program \$50M, and more patients were treated in more programs and quality was demonstrated.

Remember, both of these studies are not actuarial studies or projections; these are reports of actual experience.

We are confused when we hear people claiming that mental health costs are uncontrollable and that effectiveness cannot be demonstrated.

In analyzing the rate of increase in costs, in our experience, real increases have occurred only in the indemnity area. Once again, from the AMBHA study, in the last two years, though costs have increased by 9.5% per year in the indemnity area, increases have been held to 1% per year in the well-managed environment. That's much less than the current annual increase in the CPI.

And addressing our ability to manage cost with benefits equivalent to medical-surgical benefits . . . Milliman and Robertson re-analyzed our experience and found that we can afford equivalent mental health benefits now. Though the costs of these equivalent benefits would increase dramatically in an indemnity fee-for-service environment, costs would increase only minimally in the well-managed programs. So why not allow these equivalent benefits now?

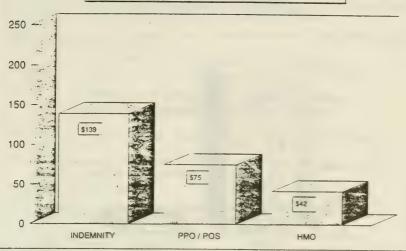
And two additional important studies are now in process and will be completed in thirty days. AMBHA will be reporting on measurements of quality and

access covering 65 million lives. And though this report will be an aggregate of several different methods of measurement, next year AMBHA companies are committing to collect the information consistently so that quality can be measured and reported on in a consistent fashion. We believe this demonstrates our commitment to measuring quality.

The second study is being conducted, again by Milliman and Robertson, for the managed behavioral care companies and the National Association of State Mental Health Program Directors. The study will report on the costs of care for not only the employed population, but the seriously and persistently mentally ill, the unemployed and the Medicaid populations on a national basis. We believe this report will lead us all to the conclusion that, to provide truly effective care, we need to integrate the delivery efforts of the public and private systems.

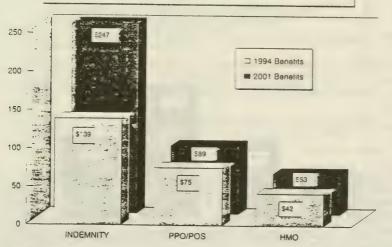
Lastly, let me say, if managed behavioral healthcare companies, with individualized case management and demonstrated quality and access, are the only approach that has demonstrated cost-effectiveness, why not require that treatment costs, quality and access be managed by psychiatric professionals in a managed care program, rather than by setting arbitrary benefit limits?

1994 Health Security Act MHSA Costs (Employed Population)



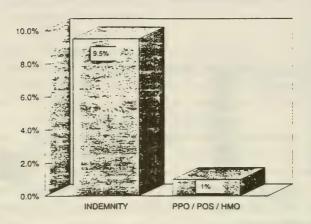
Source: Milliman & Robertson / AMBHA

# 1994 Health Security Act MHSA Costs (Coverage Equal to General Medical Benefits)

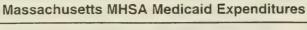


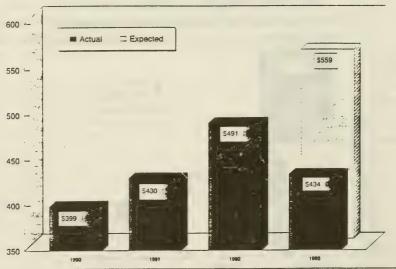
Source: Milliman & Robertson / AMBHA

1992 - 1994 Average Annual Rate of Increase in MHSA



Source: Milliman & Robertson / AMBHA





Source: Brandeis University

#### PREPARED STATEMENT OF CYNTHIA TURNURE

What I would like to do today is describe briefly the Consolidated Chemical Dependency Treatment Fund, which has been operational in Minnesota since 1988, and then discuss the implications of our data and experience for providing cost-effective substance abuse services under health care reform.

Table 1 provides an overview of the Consolidated Fund. Its original policy objectives are shown in Table 2.

#### Table 1

# OVERVIEW OF MINNESOTA'S CONSOLIDATED CHEMICAL DEPENDENCY TREATMENT FUND

- Combines a variety of funding sources with different eligibility, match, and vendor criteria
- Provides inpatient, outpatient, extended care, and halfway house treatment services through licensed providers
- Has a five year history
- Private and public providers compete for publicly funded clients and must meet the same licensing and client data reporting requirements
- Uniform placement criteria match clients to treatment settings based on problem severity
- Assessments, using uniform criteria, are conducted by trained county or reservation staff (not treatment providers)
- Rates are controlled through contracts with counties (negotiated annually).
   Rates paid through the Consolidated Fund are 10%-20% lower than those paid by other payors
- Of 350 treatment providers in Minnesota 325 (93%) are Consolidated Fund vendors
- 17,000 to 19,000 clients access treatment through the Consolidated Fund each year
- ♦ The Fund is treating one third more clients than the previous payment systems
- ♦ In 1992 Consolidated Fund payments to providers totaled \$48 million:

\$23.6 million (49%) from state general fund appropriations

\$11.1 million (23%) from federal block grant funds \$10.6 million (22%) from county funds

\$2.9 million (6%) from collections from clients, insurance companies, and the federal Medicaid program

- Inpatient placements have decreased and outpatient placements have increased since the inception of the Consolidated Fund and the implementation of standardized placement criteria; this shift resulted in a savings of \$7.7 million in 1992 (compared with a projection of the costs of former placement trends)
- The cost-per-placement for Consolidated Fund clients increased from \$2,579 in 1989 to \$2,750 in 1992 (6.6%). Over the same period other medical care costs increased 28.4%

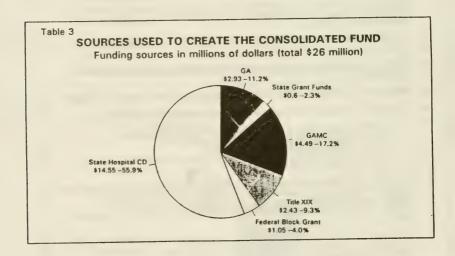
The Consolidated Fund combined treatment dollars from a variety of separate funding sources, shown in Table 3 (Medicaid, General Assistance Medical Care, our state hospitals, the alcohol and drug abuse federal block grant, General Assistance, state treatment grants), each with their own eligibility, local match, and vendor criteria, into one fund that allows the "dollars to follow the client" to the most appropriate, cost-effective programs that can meet the individual's needs. Funds are allocated to 87 counties and 11 Indian reservations on a need-based formula. Clients are assessed and placed at the local level according to statewide criteria, administered independently of treatment providers. The levels

of care covered are primary inpatient treatment, primary outpatient treatment, halfway house, and extended care. All providers in the state now compete for public clients--we no longer have a two-tiered system of treatment in Minnesota.

#### Table 2

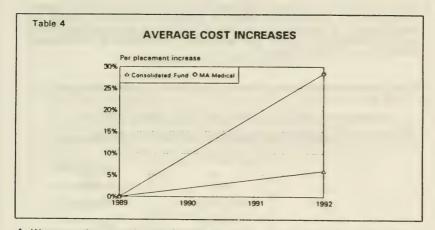
## CONSOLIDATED FUND POLICY OBJECTIVES

- Allow funding to follow the client to the most appropriate placement
- Promote the effective utilization of resources through neutralizing unequal cost sharing, sharing financial risk between the state and counties, allocating funds on a needs-based formula, and encouraging competition among providers
- ♦ Localize and standardize assessments and placement decisions
- Maintain flexibility to respond to changing conditions, including new treatment methods and local utilization patterns
- Provide a mechanism for ongoing funding of specialized programs for specific populations
- Be compatible with other cost control mechanisms such as prepaid plans and other forms of managed care
- ♦ Provide uniform information on clients, costs, and outcomes to assess results

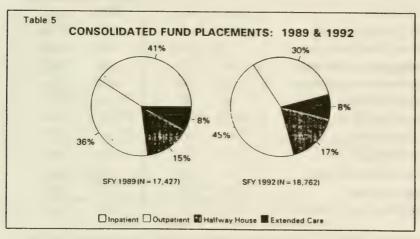


The Consolidated Fund has been successful in meeting its goals:

- We are treating one third more clients than treatment under the previous systems (approximately 20,000 a year)
- The cost of treatment increased less than 7% between 1989 and 1992 versus over 28% for other medical costs during the same period as shown in Table 4.



• We are saving an estimated \$10 million a year, due primarily to a 10% increase in the use of outpatient treatment (Table 5). Counties have also negotiated lower rates for the public client (10%-20% less than others pay), since they can guarantee volume.



Client outcomes are excellent (Table 6): Almost 60% of clients are abstinent six months after treatment and there are significant reductions in arrests and medical costs. In fact, 80% of the cost of treatment is offset within one year due to reductions in medical and psychiatric hospitalizations, detoxification admissions, and arrests (Table 7).

Table 6

# MINNESOTA CHEMICAL DEPENDENCY TREATMENT OUTCOME 1991-1992 Admissions/Comparisons 6 months before & after treatment

	clients (Public and private) N = 11,487			Consolidated Fund clients		
				(Public only)		
				N=5,131		
	Pre	Post		Pre	Post	
Abstinence rate		64.0%		***	57.0%	
Daily use rate	35.3%	15.0%		36.0%	16.1%	
Full-time employment rate	43.8%	53.8%		23.1%	41.2%	
Medical hospitalization rate	17.5%	12.8%		20.6%	14.0%	
Medical days per 100 clients	109	63		122	68	
Psychiatric hospitalization rate	7.4%	2.6%		9.4%	3.5%	
Psychiatric days per 100 clients	115	52		176	78	
Detox admission rate	18.7%	5.3%		25.9%	7.9%	
Detox admissions per 100 clients	30	9		46	15	
DWI arrest rate	23.8%	2.0%		23.8%	2.5%	
DWI arrests per 100 clients	27	2		28	3	
Total arrest rate	35.9%	5.7%		42.1%	8.5%	
Total arrests per 100 clients	54	8		66	12	

Follow-up data is based on 18.0% of 63,885 total admissions and 19.2% of 26,810 Consolidated Fund clients.

Table 7

# CONSOLIDATED CHEMICAL DEPENDENCY TREATMENT FUND ANNUAL COST OFFSETS

Almost 80% of the costs for treating chemical dependency clients through the Consolidated Fund are offset in the first year alone by reductions in medical and psychiatric hospitalizations, detox admissions and arrests.

Consolidated Fund expenditures averaged about \$50 million annually for 1991 and 1992. Comparing hospitalization, detox, and arrest rates for the six month periods before and after treatment shows dramatic reduction in all areas, even when clients who do not achieve total abstinence are included. When cost estimates are calculated for these events, the annual savings amounts to approximately \$39 million.

Here are the specifics:

#### Number per 1000 clients

Cost	6 months before treatment	6 months after treatment	ter reduction		Savings per 18,400 clients annually * *
Medical hospital					
days	1220	680	1080	\$400	\$7.9 million
Psych hospital					
days	1760	780	1960	\$300	\$10.8 million
Detox					
admissions	460	150	620	\$285	\$3.3 million
DWI arrests	280	30	500	\$1,000	\$9.2 million
Other arrests	380	90	580	\$750	\$8.0 million
					\$39.2 million

(Hospitalization, detox and arrest data from DAANES; costs are estimates.)

<sup>\*</sup>Extrapolating from 6 to 12 months
\*\*Net reduction doubled X cost per unit X 18.4

What are the implications of our data for how substance abuse should be covered in health care reform? Table 8 summarizes what we have learned.

#### Table 8

## PRINCIPLES OF HEALTH CARE REFORM

- Clients should have access to a broad range of services in least restrictive and least costly setting
- Services should be based on client need and ability to pay
- The total cost to taxpayer must be considered in placements, not just the availability of federal matching funds
- The pros and cons of various models of cost containment/ managed care should be reviewed
- Assessments and placements should be made by trained staff, based on uniform criteria, independent of treatment providers or others with financial incentives
- Services funded under health care should be coordinated with other funding sources for services such as housing, child care, etc.
- Adjunct or "wrap around" services (e.g., transportation, outreach) should be included so poor and disabled populations can benefit from treatment
- Accountability measures should be built in from the beginning
- Quality assurance standards should be required (e.g., program and counselor licensing)
- Mechanism should be included to support the introduction of new treatments
- Services must be accessible and affordable
- Ease of client access and coordination of care should supersede bureaucratic convenience
- Mechanisms should be included for prevention, early identification and early intervention
- Those with knowledge and data on specific groups should be consulted prior to finalizing coverage for that population

## I would like to emphasize three points in closing:

- 1. The best way to control the costs (both short- and long-term) of this illness is to provide flexible, individualized coverage that is based on standard assessment criteria. The proper matching of clients to the most cost-effective programs which can meet their needs is where you achieve the greatest savings, not by imposing artificial caps or limits.
- Quality assurance and accountability should be built into the new system from the beginning. Excellent models are already in use to assess and place clients, to measure treatment outcomes, and to license programs and counselors. We do not need to start from scratch in these areas.
- 3. As we move toward a one-tiered system for both the public and private client, we must plan the transition carefully so people do not fall through the cracks and then find there is no safety net. There must be adequate funding for the supplemental services needed by some clients, as well as services for those who exhaust their basic benefit, if benefits are limited in some way. And there must be flexibility for states in designing the new system to complement what they already have.

Thank you for this opportunity to present our findings and I would be glad to respond to questions at this time.

#### PREPARED STATEMENT OF HENRICK J. HARWOOD

Good morning Senators. I want to thank the Committee for the privilege of addressing you on the issue of Healthcare Reform and the coverage of substance abuse treatment. My name is Rick Harwood, and I am a Senior Manager with Lewin-VHI, Inc., a Washington D.C.-based health policy and management consulting firm. I am, however, speaking to you as a private citizen today.

I would like to offer two conclusions for the Committee's consideration.1

First, I believe that comprehensive coverage of a full range of substance abuse treatment services is not as expensive as has been suggested by some analyses. It may only cost as much as the Administration's estimate of the cost of including a limited benefit in the Health Security Act (about \$12 billion per year, or \$46 per covered life per year).

Second, incorporation of a limited substance abuse treatment benefit into healthcare reform or into health insurance plans in general will place increasing levels of burden on the publicly funded substance abuse treatment "safety net." With a limited benefit it can be predicted that chronic and severe substance abusers would experience greater difficulty in gaining access to appropriate care than is currently the case. This could only be avoided by maintaining a strong publicly-funded "safety net" for those that exhaust their limited benefits.

Healthcare reform holds out both a significant opportunity and a major threat to the goal of providing universal and timely access to effective substance abuse treatment. The threat is posed by reforms that would implement a limited benefit that does not provide for a full continuum of services needed by individuals with drug and alcohol problems, while at the same time inadequately funding the existing publicly funded system that has served as a "safety net" for all individuals, whether privately insured or not.

The opportunity exists to fashion a comprehensive substance abuse benefit to:

- · provide universal and timely access to substance abuse treatment;
- cover the complete continuum of services (from clinical preventive services, to acute hospital care, extended residential and ambulatory services, and continuing care);
- · provide for adequate quality, intensity and duration of care; and
- · use uniform assessment and placement criteria.

It should be emphasized that there are different ways in which this goal can be achieved, encompassing private market-oriented systems, public systems of various types and "mixed" systems. This analysis does not endorse a particular approach. Rather, the objective is twofold: first, it will illuminate some fundamental characteristics of the current system of financing substance abuse services. Second, it will examine the cost and treatment utilization of five broadly-cast, alternative approaches to reform, including the Administration's substance abuse benefit as described in the Health Security Act.

This report does not examine the implications of subtle changes in coverage, such as differences in deductibles and copayments, or specific types or amounts of services. The data and empirical literature on the financing of and demand for substance abuse treatment is not adequate to provide support for such analysis.

<sup>&</sup>lt;sup>1</sup>This testimony is drawn from a Lewin-VHI, Inc. Final Report entitled "Healthcare Reform and Substance Abuse Treatment: The Cost of Financing Under Alternative Approaches," sponsored by the Legal Action Center, the National Association of Addiction Treatment Providers, the National Association of Alcoholism and Drug Abuse Counselors, the National Council on Alcoholism and Drug Dependence, and Therapeutic Communities of America.

Summary statistics for the current treatment system and the five alternatives are presented in Exhibit A. Because the alternative proposals have different objectives in terms of the publicly- and privately-reimbursed treatment systems, respectively, the summary data are presented for these two treatment delivery sectors, as well as for the complete national treatment system.

#### The Current System

It is estimated that in 1993 about 3 million persons obtained specialized substance abuse treatment at a cost of about \$6.7 billion. This generally excludes care not delivered by specialized providers, such as treatment of substance abusers in the general wards of hospitals, or by most physicians in their offices. Hospital care delivered in specialty wards accounts for about \$1.7 billion, versus \$2.2 billion for outpatient treatment, \$1.1 billion for long-term residential, \$950 million for short-term residential, \$480 million for methadone treatment \$250 million for detoxification centers and \$90 million for private practitioners (e.g., psychiatrists and psychologists). These estimates include the cost of about 600,000 hospital-based inpatient episodes delivered in specialty wards at a cost of almost \$3,000 per admission.

Inpatient treatment episodes delivered in general hospital wards are excluded from the above estimates and all subsequent calculations because: such care does not generally provide specialized rehabilitation services for substance abuse; is often motivated by comorbidities of substance abuse (e.g., liver disease) or acute emergencies related to alcohol or drug poisoning/overdose or withdrawal. Most importantly, these costs should not generally be attributed to a substance abuse treatment (rehabilitation) benefit because such acute care would virtually always be delivered to an afflicted patient even if substance abuse services were not covered in an acutely "life-threatening" situation.

Most of the \$6.7 billion in 1993 funding came from public sources (\$4.33 billion), with private insurance payments of \$1.6 billion and client payments of \$770 million. It is plausible that 20 percent of public reimbursements are for clients that have private health insurance. Roughly 160 million persons had private health insurance, and another 100 million persons depended on public financing of health services through Medicaid, Medicare, the Department of Veterans' Affairs, or direct funding of care for the uninsured.

There are major differences in the types of care purchased by private insurance and by public financing. Private insurance purchases proportionately more hospital and short-term residential care, while public programs generally provide more outpatient and long-term residential care. Privately-reimbursed care usually has limits on the amount of care that will be reimbursed, and is generally of significantly shorter duration than publicly-reimbursed treatment. These differences between care reimbursed under private insurance and by publicly-subsidized programs are the primary source of the differences between the five general approaches to healthcare financing reform that are analyzed below.

#### A Comprehensive Benefit

A comprehensive substance abuse treatment expansion and improvement benefit similar to that proposed by the Legal Action Center (LAC) is estimated to cost \$11.725 billion per year (\$45.10 per person in the U.S.). This is \$4 billion above the \$6.7 billion that will be spent to treat 3 million persons in 1993 (\$25.75 per person). The comprehensive benefit would apply to both private and public health insurance plans, with provisions for patient assessment and referral, coverage of a complete range of services, generous limits on services, and increased intensity of therapeutic services with increased levels of reimbursement for non-hospital services

Under a comprehensive benefit improved quality treatment would be delivered to 3.3 million persons per year, who would utilize a total of 6.3 million treatment episodes. These estimates are dependent on the assumption that a comprehensive plan would increase the number of persons accessing care by 10 percent. It is possible that the increase could be greater than this level, based on the experience of the Minnesota Consolidated Fund, and the differentials in utilization of general health care services between the uninsured and insured populations.

#### The Health Security Act Proposal

The Health Security Act (HSA) by itself is unlikely to alleviate the existing problem of limited access to substance abuse treatment. Up to 60 million currently uninsured and Medicaid beneficiaries will gain coverage under Health Plans set up under the HSA. However, both this population and those currently insured will continue to have a heavy reliance on publicly funded treatment for a number of years. This is because coverage under the HSA is oriented to "brief interventions" and short-term treatment and generally would not cover more intensive and longer-term services many of the 3 million clients in substance abuse treatment now receive.

The 225 million persons that would be enrolled in Health Plans would use Plancovered substance abuse treatment services costing \$3 billion. Plans would pay \$2.3 billion, and patients would make copayments for plan-covered services of \$754 million. Estimates are based on 1993 population and costs. However, this would provide only relatively short duration services that may not be appropriate for severe/chronic substance abusers. Consequently, such individuals would need to make recourse to the publicly-subsidized treatment system for further treatment. Costs for services in excess of those covered under the HSA for the 225 million persons in Health Plans could require an additional \$2.24 billion in publicly-funded treatment services (plus out-of-pocket payments of \$121 million). This is the cost for enrollees to receive about the same level of care currently being utilized.

The 35 million persons not expected to join HSA Health Plans--the disabled and elderly Medicare population and others reliant on government programs (e.g. veterans, Native Americans)--are expected to continue to require \$1.4 billion in publicly-funded substance abuse services and pay about \$75 million out-of-pocket for these services

## Improved Public "Safety Net" Coverage: The Minnesota Consolidated Fund

If health care reform does not happen, or takes a limited approach either in terms of how many people are covered, or what or how many services are covered it will be incumbent to maintain a publicly-subsicized substance abuse treatment "safety net". One approach analyzed was modeled after the Minnesota "Consolidated Fund".

The Consolidated Fund: covered those with low incomes; uses standardized assessment and referral criteria; coordinates disparate public payment sources (Medicaid, General Assistance, state appropriations and Federal Block Grant funds); and covers a broad range of services (e.g., hospital, residential, outpatient and combined, but not detoxification services). Costs of using this approach are relatively high because the Minnesota Consolidated Fund pays for relatively more inpatient and residential care than is customary in other states, and average stay in treatment appears to be greater. A typical treatment admission costs Minnesota about \$2800, compared to a national average of about \$1200. Therefore, while the Consolidated Fund may be an appropriate model for building an improved "safety net," it is not clear that the cost of services would mirror the Minnesota experience.

Under this approach it would cost the public system \$11.5 billion to treat an estimated 2.3 million persons, who would utilize 4.4 million episodes of publicly-subsidized care. There would also be continued costs of \$2.17 billion for the privately financed system, for total costs of \$13.7 billion. Based on the estimate that about 20 percent of publicly-subsidized treatment is provided to privately insured persons, this suggests that \$2.236 billion in public treatment funds would go to subsidize those with private insurance (with out of pocket payments of \$119).

#### An Expanded Private Insurance Residential and Outpatient Benefit

This proposal would yield clear benefits for privately-insured patients, and might provide about \$500 million in relief to the public treatment system by reduced use by privately-insured patients. The proposal would require private insurance coverage of short-term residential treatment (and substitute this type of care for much rehabilitation currently delivered in hospitals) and would increase the reimbursable amount of ambulatory care up to 130 hours per year. Such a proposal would result in a modest increase in treatment expenditures for privately-insured individuals, from \$2.11 billion under the current plans to \$2.36 billion per year (for both insurance payments plus client out-of-pocket payments). This would pay for increased amounts of treatment of 1 million individuals that currently obtain substance abuse treatment under private insurance.

The proposal implies significant shifts for privately insured individuals in where and how services are delivered: hospital utilization would drop from \$1.067 billion (for 219,000 patients) to \$355 million (for an equivalent of 73,000 patients); short-term residential services would rise from \$385 million (for 153,000 patients) to \$825 million (for an equivalent of 239,000 patients); and outpatient services would increase from \$497 million to \$1.009 billion for the same number of clients due to a significant increase in the length of stay.

It is assumed that the publicly-subsidized system would maintain funding and services at its current level, however there would be a material reduction in the utilization of this financing system by those with private insurance. The publicly-subsidized treatment system could gain about \$500 million from reduced use by privately-insured individuals that exhaust their coverage and need more treatment. This could be used to expand services for those without private insurance.

# Limited Private or Small Market Reform

Enactment of a very limited private insurance benefit modeled after "tightly managed" benefits often provided by HMOs (and increasingly used by many private insurance plans) would cost insurance plans \$1.49 billion (\$9.30 per covered life per year). The minimum coverage would be 30 days per year for inpatient/residential care, and 20 outpatient visits, with heavy reliance on managed care to keep treatment episodes down to short durations and exclusion of chronic/severe patients (with referral to the public "safety net" programs).

The public system would require funding of \$5.97 billion in order to treat its current clients plus treat the additional privately-insured clients that might no longer receive treatment under this approach to reform.

Based on service delivery patterns of HMOs it is projected that 5.3 million of the 160 million privately-insured persons per year would access some substance abuse-related service, but only 740,000 treatment episodes would be delivered to 390,000 persons--the remainder would receive other services such as "brief interventions." This would imply a decrease of about 610,000 persons receiving privately-insured treatment, that could potentially place an added requirement for \$1.4 billion in treatment services on the public system (over and above the \$866 million currently delivered to privately insured persons persons by the public system).

#### Conclusion

I again want to thank the Committee for this opportunity to address you.

EXHIBIT A
SUBSTANCE ABUSE EXPENDITURES AND CLIENTS SERVED IN 1993
AND UNDER FIVE HEALTHCARE REFORM PROPOSALS

	Current	Compre-	Health	Minnesota	Private Sector	
	System	hensive	Security	Consolidated	Expanded	Limited
		Plan	Act	Fund	Benefit	Benefit
Total System						
Expenditures (\$ in Billions)	\$6.70	\$11.73	\$6.742	\$13.72	\$6.93	\$7.46
Lives Covered (Millions)	260	260	260	260	260	260
\$ per Covered Life	\$25.75	\$45.10	\$25.90	\$52.75	\$26.65	\$28.70
Annual Clients (Millions)	3	3.3	3	3.3	3	3
Admissions (Millions)	5.8	6.4	5.8	6.3	5.8	5.7
ALOS (Days/year)	125	145	101	155	137	130
Publicly-Subsidized System						
Expenditures (\$ in Billions)	\$4.57	NA	\$3.69	\$11.55	\$4.57	\$5.97
Lives Covered (Millions)	100	NA	35	130	100	100
\$ per Covered Life	\$45.70	NA	\$105.45	\$88.85	\$45.70	\$59.70
Annual Clients (Millions)	2	NA	1.6	2.3	2	2.6
Admissions (Millions)	3.9	NA	3.1	4.4	3.9	4.95
ALOS (Days/year)	140	NA	140	194	140	140
Public Subsidy to Privately						
Insured (\$ in Millions)	\$866	NA	\$2,284	\$2,236	\$300	\$2,198
Privately-Reimbursed System						
Expenditures (\$ in Billions)	\$2.17	NA	\$3.05	\$2.17	\$2.36	\$1.49
Lives Covered (Millions)	160	NA	225	160	160	160
\$ per Covered Life	\$13.55	NA	\$13.55	\$13.55	\$14.75	\$9.30
Annual Clients (Millions)	1	N'A	1.4	1	1	0.39
Admissions (Millions)	1.9	NA	2.7	1.9	1.9	0.74
ALOS (Days/year)	65	NA	65	65	130	63

Source: Analysis by Lewin-VHI, Inc.

ALOS: Average length of stay, or time enrolled in treatment per year.

February 23, 1994

Representative J.J. Pickle Congress of the United States 10th District 763 Federal Building Austin, TX 78701

Dear Representative Pickle:

The Clinton Administration stands ready to announce a national plan to end homelessness, developed by Assistant Secretary of Housing Andrew Cuomo and HUD Secretary Cisneros. I believe that it is essential—on economic, logal, and moral grounds—that any effective plan to end homolessness include provision for diverting persons who are mentally disabled from jail and into treatment (including treatment for alcoholism if necessary) and into appropriate orisis—or supervised housing.

<sup>&</sup>lt;sup>2</sup>The Administration has estimated current expenditures on substance abuse treatment at \$11 billion, or about \$48 per covered life for about 230 million persons (Memorandum dated January 5, 1994 from the Office of Health Policy, DHHS). The large difference between this study and Administration estimates is due to their use of much higher estimates of the cost of hospital care for substance abuse treatment.

Unfortunately, hundreds of thousands of persons who are seriously mentally ill or dually diagnosed are homeless or at-risk of becoming homeless, including many here in Austin and many who are United States voterans. As you know, a great many of these persons are being incarcorated even though they are charged with no crime or with a non-violent misdemeanor. I know well the kind of heart-break this can cause, because I have had to see my own daughter put behind bars for trivial charges which resulted from her mental illness.

Our response in Austin to tragedies such as this has been heartening. For the past decade, Austin-Travis montal health deputies, the Austin State Respital, our Community Center and appropriate housing resources have successfully diverted persons who are mentally ill from jail and prevented homelessness. New programs, such as the Access and Anew programs, will help. But availability of state hospital beds is limited and need for supported housing is great.

Although in the past sistes were solely responsible, the passage of the Americans Vith Disabilities Act (ADA) makes clear that the federal government has a crucial role to play in ending discrimination and ensuring equal access to services and programs.

A specific office of the federal government should be made accountable for ensuring that the necessary resources and technical support are made available to local governments and used effectively on behalf of this special needs population. Otherwise, vast sums of money will continue to go toward law enforcement costs, court costs, and jail costs to incarcerate persons who may be elderly or homeless or veterans and badly in need of medical care.

I would like to offer my deepost thanks for your previous help and my hope that you will inquire about these issues (as outlined in the enclosed letter) in keeping with the towering legacy you've provided for each of us in Austin, for all our Texas neighbors, and for America.

Sincerely,

Conercere Carlon Hearon

February 23, 1994

Andrew Cuomo
Assistant Secretary
Community Planning and Development
U.S. Department of Housing and Urban Development
Washington, DC 20410-7000

Dear Assistant Secretary Cuomo:

We believe that a little-noticed but profound shifting (and sharing) of legal responsibility from the states to the federal government—has occurred, involving the well-being of every American who is seriously mentally iii.

As you know, public provision for these citizens has historically been the responsibility of the fifty states. Only recently have Medicaro, Medicaid, and federal funding for community mental health centers come into play.

In our judgment, however, passage of the Americans With Disabilities int has substantially enhanced the federal government's mandate and responsibility to reverse the widespread lack of services and the discrimination encountered by these individuals.

We contend that the number of persons who are mentally ill and either homeless or wrongfully incarcerated in this country will be inversely proportional to the degree to which the federal government discharges this newly extended responsibility.

State control over persons who are mentally ill has been not entirely dissimilar in its outcome from the effect of the doctrine of state's rights, once used to protect racism in America. Today, fortunately, the federal government intervenes to protect minorities from discrimination and to assist their businesses and communities.

Only when mentally ill persons are no longer viewed primarily as a state problem, and when they are no longer illegally denied equal access to health care, or treatment for alcoholism, or housing, will the day perhaps come when hundreds of thousands of them—many of them yeterans of United States military service—will no longer live in alleys or in Isile.

In view of the above, we propose that—on sconomic, legal, and moral grounds—any comprehensive plan to end homelessness in America must provide systematically for diverting persons who are mentally disabled away from jail and into treatment and appropriate orisis—or supervised housing.

We salute the Justice Department's efforts to identify and end such discrimination, while also recognizing that the Justice Department is not charged with funding or knowing how to implement adequate services for persons who are mentally ill and at-risk of homelessness or incarceration.

We hope that the Secretary and you will consider stating publicly that HUD's national comparing to end homelessness is an integral component of the national commitment to enforcing the Americans With Disabilities Act, a commitment that will include local, state, and federal cooperation.

In addition, we hope that diversion programs leading away from jall and into a continuum of care (including treatment for alcoholism) and a continuum of housing in the community will be developed as a core piece of HUD's attack on homelessness.

We extend our thanks to you for giving this your consideration, and we look forward to your response.

Sincerely,

Jonathan D. Ezekiel

Genevieve Tariton Hearon

Secretary
Housing and Urban Development

Representative J.J. Pickle 10th District Austin, Texas 646



Fobruary 25, 1994

Henry Cisneros Secretary U.S. Department of Housing and Urban Development 451 7th Street, S.W. Washington, DC 20410-7000

Dear Secretary Cisneros:

We have shared with you in previous communication our concerns about persons who are soriously mentally ill and at-risk of becoming incarcerated or homeless. In fact, since we last wrote to you about it, the Justice Department investigation into violations of Title II of the Americans With Disabilities Act has widened in scope to include 21 public entities in 9 states.

The accompanying letter grows out of that work and is, if anything, more important. We believe that passage of ADA has profoundly altered the relationship between the federal government and city/county/state governments regarding responsibility for persons who are mentally ill.

The inadequate coordination of care for this population among cities, counties, and states, and the imbalances in care across state lines, have created and perpetuate the very inequities that ADA was designed to redress. Our outdated, pre-ADA notion of state responsibility for persons who are mentally ill has led to endless attempts by government at every level to shift costs and responsibilities, rather than create effective services.

The result: we have a fragmented, dysfunctional mental health system in America, where patients are discharged from state hospitals to save money and to qualify for federal benefits, or are diverted to county jails instead of city hospitals, or given "bus therapy"—one-way tickets outside the city/county/state line, dead-ending in homelessness or incarcoration.

In this bloak landscape, your continued leadership on behalf of homeless persons, particularly your elequent public pleas during the Christmas season for renewed action from jurisdictions across Americu, are truly welcome. After listening for so many years to attacks on government from those whose responsibility it should have been to make them work, we realize we are fortunate to have in the former Mayor of San Artonio a friend who knows both effective government and the power of the bully pulpit.

If our analysis in the accompanying letter holds, please let us know your plans for integrating mental health policy as a national responsibility rather than a state or provincial one.

Respectfully yours.

atten B. Galler

Jonathan D. Ezokiel

Genevieve Tarlton Hearon

Senator JEFFORDS. Thank you. With that, the hearing is adjourned.

[Whereupon, at 1:05 p.m., the committee was adjourned.]



